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Though the government spends billions of dollars a year on healthcare for the poor, the indigent populations of America unarguably receive poorer healthcare and less access than their middle class counterparts. Healthcare is a constant topic of debate from private homes, to university classrooms, to the floors of congress, but all too often the availability and need for mental health care in indigent populations is neglected.

In her book, *Uninsured in America*, Susan Sered documents the troubles of one Mexican-American mother in the Rio Grande Valley to gain adequate healthcare for her daughter. Her daughter Guadalupe suffers from what is probably borderline personality disorder, and has been constantly shuffled back and forth from one government system to the next. Sered asserts that Guadalupe's problems would probably be addressed much more competently if she were suffering from a physical illness rather than an unseen and elusive mental illness (Sered 2005).

This is the case for many indigent populations across the country suffering from mental disorders. The level or rate of indigent people in a particular population is constantly changing and almost impossible to measure, but it can be fairly accurately assessed by the percent of the population that is uninsured. Texas, which leads all states in the percentage of its population lacking health insurance, has an uninsured rate of 24 percent; and even with expensive new health insurance programs meant to help children of indigent families such as

CHIP, the rate of Texas' uninsured children is also the highest in the country, at 21 percent (Pugh 2003, Center for Public Policy Priorities 2005).

The relationship between socioeconomic status and mental disorders is highly controversial and increasingly complex. To summarize the general consensus, one study found that poverty and unemployment were associated with the maintenance of mental disorders, but not their onset. Poverty and unemployment increase the duration of episodes of mental problems as well as their severity but do not appear to be the initial cause (Weich and Lewis 1998). Additionally, compared with the general population, individuals with poor mental health experience a significant deterioration in health insurance status. This pattern does not appear among people with chronic physical ailments (RAND Health 2000). These findings suggest a dangerous spiral effect for indigent mentally ill people. Though their mental illness may be onset by factors that are not socioeconomic, their problems maintaining it could cause them to lose their jobs, (and therefore their health care coverage), eventually lose their mental health care and therefore cause their mental problems to deteriorate even further making it difficult to regain any kind of employment. Highlighting this disturbing pattern is the statistic that the unemployment rate for mentally ill populations is three to five times higher than for the rest of the population (RAND Health 2000). The most important thing to ascertain from the above data is that though low socioeconomic status probably does not cause

mental disorders, it exacerbates existing mental problems and causes a downward spiral of economic loss and a deterioration in mental health.

To complicate the issues of indigence and mental healthcare even further, the relationship between mental health professionals and the poor has been the subject of controversial discussion for decades. The problem of mental health care and its availability for lower income individuals first surfaced in the 1960s with the community mental health center movement. The debate among psychologists has fluctuated constantly regarding the applicability of current mental health interventions for the poor. The absence of poor people in private mental health practice has been well documented and is regarded by some as evidence of classism in the field. While it is more likely that this phenomenon is a combination of the lack of health coverage and lack of knowledge or access to private mental health care, the problem of the absence of indigent people served still persists. Though some say poor people are less responsive to mental care, most mental health professionals agree “that if therapists have the skills and awareness to keep low socioeconomic status patients in treatment beyond the first few interviews, the outcome is at least as good as with higher socioeconomic status groups” (Smith p. 689, 2005).

Now that the relationship between mental health and indigence as well as the effectiveness of mental health interventions for indigent groups has been established, it is necessary to discuss the definition of indigent in more detail. Indigent people are obviously individuals of low socioeconomic status, but since there is little literature on indigent populations and their mental health in general, to study this group and its relationship to mental health in detail we must separately examine several groups or categories that make up the majority of the indigent population. These groups include people living in rural areas, minorities, homeless people, and the incarcerated. This is not meant to imply that all or even most members of each of these groups are poor only that it is highly

likely that a poor individual belongs to one or more of these groups.

The first category where many indigent people are found is among rural people. The majority of individuals living in rural areas (57%) usually depend on farming or manufacturing for their economic well being. Over the past few decades these sectors of the economy have declined in their size and profitability. Even without necessarily being indigent, people in rural areas have extremely limited access to mental health care. Specifically, there are 1,682 counties in the U.S. lacking a psychiatrist, psychologist or social worker, and all of them are rural. It may take a rural person hours of traveling to reach a qualified therapist, and for many treatments people are expected to come to therapy several times a week. This causes obvious problems for the many people living in rural areas because they are unlikely to have the time or means of transportation to reach a qualified mental health care practitioner (Fox 1995).

Some may assume that because rural populations are not exposed to problems and dangers in the city they are less likely to need mental health services but this claim is not supported by fact. Nearly 60 million Americans that live in rural areas have the same mental health problems and need for services as the individuals living in urban and suburban areas. This figure is particularly disturbing considering the tremendous barriers to mental health care, discussed above, experienced by rural people. These barriers, such as the time and money it takes to reach a mental health care professional, cause complications with the care rural people do receive. Because of the lack of available mental health care rural people experiencing mental problems often go to their primary care physicians, who usually lack the training, time, and resources to diagnose and treat mental illness. Additionally, though the National Institute of Mental Health (NIMH) found that rural people usually have health care coverage rates comparable to people in urban and suburban areas, their insurance is much less comprehensive. Most importantly, many of the insurance plans used by rural people do not

cover any kind of mental health care, presenting another barrier to their mental health care access (NIMH 2005).

In addition to the rural population, minority groups in the U.S. including Hispanics, African Americans, Native Americans, and Asian Americans are also overly represented in the indigent population. For example, in Texas, 61.8 percent of Hispanics are uninsured compared to only 26.8 percent of non-Hispanic whites. For this reason, many Mexican Americans in the Rio Grande Valley and from throughout the state resort to getting their medical care in Mexico which may be less effective and possibly even dangerous but it is less expensive than traditional U.S. health care (Sered 2005). While virtually all minority groups in the U.S. receive less mental health coverage than whites, interestingly, Asian-Americans experience the worst discrimination. The Surgeon General reported that Asian Americans and Pacific Islanders have the lowest rate of healthcare among all the minority populations regardless of age, gender, or geographic location (Lu 2002). There are several possible cultural factors involved in this high percentage such as the shame associated with having mental problems, but it is also a result of the lack of access, coverage, and information about health care and mental disorders available to this “model minority.” The lack of mental health care available to minorities is probably caused by some combination of cultural differences, economic disparity, or decreased resources or knowledge of mental health problems and treatments. These problems must be addressed by the public and the field of mental health in order to promote understanding and decrease the prevalence of mental illness in populations with a high rate of indigence.

The next indigent category to discuss is America’s homeless population. There is an obvious correlation between being homeless and being poor. A strikingly high 20 to 25 percent of homeless people have a serious mental illness. Serious mental illnesses include the most debilitating of all mental disorders such as

bipolar disorder, schizophrenia, and major depression. To complicate matters even more, of this 20 to 25 percent, half of them also have an alcohol and or drug abuse problem. In addition to just being extremely poor, minority groups discussed above, especially African Americans, are over represented among homeless people with mental illness. Though it is unclear which comes first, the mental disorder or the homelessness, it appears that the more factors relating to indigence a person has, such as belonging to a minority group and being homeless, the more likely one is to have a mental illness (National Mental Health Information Center 2005).

Another group of the population that is often neglected when discussing the indigent and the mentally ill are the incarcerated. Although they have high rates of both mental illness and indigence, because they are institutionalized, incarcerated people are rarely counted in surveys and studies focusing on the poor or mentally ill. In fact, mental illness is so common in prisons that jails have become the largest de facto providers of mental health services in many cities across the country. Unfortunately, due to the lack of infrastructure in our mental health system designed to help the indigent mentally ill, jails and juvenile detention centers are often the first line of treatment for these individuals. Between 600,000 and 1 million jail admissions each year are people who suffer from one of the severe mental illness (major depressive disorder, schizophrenia, or bipolar disorder). Most notably, rates of the most severe mental disorders are two to three times higher in jails than in the general population (Harrington 2000). It is important to keep in mind that these startling statistics are only measuring the most severe mental illnesses and do not include other very common disorders such as anxiety disorders, personality disorders or substance abuse disorders.

The current social structure in place to treat the poor and mentally ill is incredibly inadequate and often self defeating. Persons with low incomes, who have mental disorders, so often go untreated that they resort to petty crimes.

Police arresting them for these petty crimes have the choice to commit them to local mental health care systems; but, because the systems are so inadequate the police usually take them to jail where they are treated for their disorder with therapy and medication. Upon release from jail the mentally ill person is healthier than ever before, but does not have the means to obtain mental health care. The former incarcerated are commonly neglected by the local health care systems and therefore often spiral back into their devastating cycles of mental illness and crime. Harrington sums up this problem in the following quote, "In too many states, a ping-pong game has developed between jails and community mental health centers in which the indigent mentally ill are swatted back and forth between institutions. This situation benefits no one...the ping-pong game is expensive and not in the best interests of public safety" (Harrington 2000). This process, which the indigent mentally ill are resigned to, has been appropriately termed the "criminalization" of the mentally ill.

There are additional problems for the mentally ill once they end up in jail. Though the prison systems may be the only place the indigent mentally ill prisoners have ever received treatment it is not their primary purpose. Jails often do not have the adequate staff or training to implement effective treatments or medication. Additionally, though they may be receiving treatment for the first time, once in jail the mentally ill do not necessarily fare well. Their mental disorders put them at an increased risk for suicide, victimization, and sexual abuse by other inmates. Perhaps the most discouraging

news is that of those mentally ill that are able to attain treatment in prison, only one-third of them receive continuing psychiatric services once they leave jail. Since these numbers include only the severely mentally ill their need for psychiatric services continues once they leave prison. The lack of post prison care is a serious problem. In the case of the severely mentally disturbed, it will most often lead to a relapse into psychosis and a loss of any gains made in prison.

Through the evidence presented above it is obvious that indigent populations suffer from a higher rate of untreated mental disorders than their middle class counterparts. This problem is probably not directly caused by indigence but is exacerbated by factors associated with it such as the lack of health care coverage and knowledge of community mental health systems. Though the problems for indigent and mentally ill populations are devastating, there are several policy implications and solutions possible to alleviate this problem. Specifically, several studies have been done regarding the efficacy of telecommunication medicine for rural populations. So far, telemedicine used to diagnosis and treat mental disorders in the form of internet therapy or CD-ROM mental health education has yielded promising results (NIMH 2005). Additionally, the efforts of the community mental health centers originally designed to treat the indigent mentally ill must improve dramatically to effectively treat this challenging population. This implies a need for an increase in community awareness and funding to develop and provide access to mental health centers.

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