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Barriers in the diagnosis and treatment of depression in women in the USA: where are we now?

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An estimated 14.8 million Americans aged 18 years and older, or approximately 6.7% of the adult US population, meet the criteria for major depressive disorder in any given year [1]. Women are almost twice as likely as men to report lifetime history of a major depressive episode, with their first episode occurring in adolescence through to mid-life [2]. An estimated 8–16% of US women aged 18–44 years are affected by depression [2,3]. Existing research has found depression to be associated with many adverse conditions throughout life, including concurrent psychiatric and substance use disorders, chronic conditions such as diabetes, decreased fertility, poor pregnancy outcomes such as preterm delivery or low birth-weight infants, and impaired maternal functioning and bonding.

Compared with men, women are more likely to visit their physician [101] and frequently interact with the healthcare system, especially during reproductive years [102]. However, only half of women with depression receive a clinical diagnosis [3], which is often the first step to treatment. Studies have shown that women who are younger, non-Hispanic white and uninsured are less likely to receive clinical diagnoses [3,4]. These groups are also less likely to seek treatment [5] and to receive appropriate treatment when care is sought [6]. Barriers to care have been well documented in the literature and include financial constraints such as healthcare coverage, fragmented care and stigma [3,7]. Given these constraints, addressing barriers in diagnosis and treatment of women with depression must be a multifaceted approach.

Addressing financial constraints including lack of healthcare coverage

Lack of health insurance is often a barrier to receiving care for depression. The Affordable Care Act (ACA) of 2010 increases access to health insurance coverage through a number of provisions, including employer coverage requirements, small business tax credits, refundable premium subsidies and health insurance exchanges [103]. Additionally, the ACA's expansion of Medicaid could provide coverage for up to an estimated 10 million currently

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uninsured women, who may only have healthcare coverage during pregnancy and postpartum periods [104]. Inclusion of mental health and substance-use disorder services as part of the essential benefits package, incentives to coordinate primary care, mental health and addiction services, and elimination of pre-existing condition exclusions may also improve access to care among women with depression [103].

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Improving clinician skills & coordination of care

One approach to reducing barriers is to improve the coordination of care by enhancing providers' knowledge and skills in screening, diagnosis and treatment. Improving skills among providers who frequently interact with women, such as obstetricians/gynecologists, pediatricians and primary care clinicians, may be especially effective. Provider interest in gaining knowledge and skills in this area may differ by specialty and committee opinions of their professional organizations. For example, in 2009, the president of the American Congress of Obstetrics and Gynecology (ACOG) took on perinatal mental health as a key priority area of his tenure. A concurrent survey of randomly sampled ACOG fellows found that only a third reported taking a continuing medical education course on postpartum mental health [8]. However, those who took the course were more likely to report using validated questionnaires to diagnose patients, routinely asking about symptoms and tracking women with histories of postpartum psychological disorders than non-course takers [8].

Integrating screening for depression into visits with obstetricians/gynecologists, pediatricians and primary care clinicians can improve identification of depression among women, but effects on treatment uptake are less positive. For example, studies that have evaluated universal screening in these settings among women enrolled in state Healthy Start and Medicaid programs, have found no observed changes in treatment usage [9,10]. In these studies, women who screened positive during integrated screening received referrals to other providers, presenting another barrier to diagnosis and treatment. Much of the existing literature has evaluated similar screening and treatment referral models; a 2010 ACOG committee opinion found insufficient evidence to support a firm recommendation for universal antepartum or postpartum screening [11]. Substantial effort to encourage women into care and alleviate barriers by providing outreach, child care, transportation and flexible schedules of care, was found to increase treatment among women who had previously received integrated depression screening at Women, Infants and Children food subsidy programs or county-run Title X family clinics [12]. However, this level of effort is unrealistic in clinical practice.

Incorporating both screening and diagnostic assessments, as well as treatment engagement strategies within the same visit, is feasible and has the potential to increase treatment rates. In a study of primarily Hispanic women, those who screened positive during a perinatal visit were immediately given a brief diagnostic assessment that incorporated treatment engagement strategies such as an explanation of the diagnosis in culturally congruent, easy-

to-understand language; 90% of women who received a diagnosis during their perinatal visit initiated treatment [13]. Algorithms and guidelines for treatment decisions, phone- and internet-based provider support from mental health experts, and referral to on-site care also have the potential to improve treatment rates among women who are screened for depression [7].

> "…research is needed to understand which culture-specific factors influence stigma towards depression and its treatment, in order to develop successful initiatives and campaigns to reduce stigma as a barrier to diagnosis and treatment."

Reducing stigma

Stigma has historically surrounded mental illness and remains a complex issue. Existing literature indicates that culture-specific factors, such as a greater reliance on social support and religion, differential presentation of depressive symptoms, mistrust towards the medical community, and fear of legal or child-protective issues, may all influence stigma and whether a woman seeks and continues treatment [14]. Reducing stigma may alleviate disparities in screening and treatment for depression [14]. However, we do not fully understand what effectively reduces stigma. In the past three decades, many initiatives have been launched to reduce stigma surrounding mental illness, including the 1980s educational campaign Depression Awareness, Recognition and Treatment Program sponsored by the NIH, the National Alliance on Mental Illness' Campaign to End Discrimination and the more recent campaign, Depression Is Real. However, one study found that stigma towards individuals with mental illness did not change between 1996 and 2006, despite the fact that the belief that mental illness has a neurobiological origin has increased [15]. Another study found that stigma towards mental health treatment may be declining, as more individuals in 2001–2003 were willing to seek professional help than individuals in 1990–1992 [16].

Conclusion

The ACA of 2010 may help reduce some of the financial barriers to treatment among women due to insurance coverage. However, more work is needed to improve coordination of services and integration of both screening and treatment in places where women seek care. Additionally, research is needed to understand which culture-specific factors influence stigma towards depression and its treatment, in order to develop successful initiatives and campaigns to reduce stigma as a barrier to diagnosis and treatment.

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