Barriers to Help-Seeking, Detection, and Adequate Treatment for Anxiety and Mood Disorders: Implications for Health Care Policy

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Recently, the focus of health policies and initiatives has been directed toward mental health. More precisely, depressive and anxiety disorders have received particular attention because of their disabling outcomes and prevalence among most populations. Despite this increased interest, numerous issues regarding patients' willingness to seek treatment and the adequate recognition and treatment of these disorders by clinicians remain to be addressed. This article considers the factors that influence patients and physicians in their reticence to acknowledge and adequately treat depression and anxiety disorders. It also reviews the impact of society and the media, together with other factors relating to health care organization and administration that affect the treatment of depression and anxiety. In view of the multifaceted challenge involved, efforts to achieve a consensus in determining treatment for those with depressive and anxiety disorders are essential. A consensus will require easy, measurable, and reliable disability indicators; evidence that treatment of patients with varying levels of need is cost effective; and that persons who most need and would benefit from care can be reliably identified among the highly prevalent population of persons with more transient symptoms. Governments and other policymakers should be encouraged to provide appropriate coverage for access to primary and secondary care, the treatments required, and sufficient resources so that care is available when necessary. An important aspect of the challenge is to incorporate these efforts within the realistic constraints of primary care.

(J Clin Psychiatry 2007;68[suppl 2]:20–26)

The term *health policy* as used in this paper refers to the broad range of investments, incentives, regulations, and strategies used by health authorities to influence access, use, cost, and quality of health care. Such policies are made and/or implemented by different policymakers at national, regional, and local levels. Such initiatives include designing national entitlement and reimbursement schemes, establishing formularies, regulating the approval of devices and drugs and their reimbursement, manpower development, and programs for professional and public education. Policy decisions made at local institutions may affect access and referral to professional personnel, practice arrangements including involvement of nonphysicians, quality assessment, and monitoring and regulation of performance.

In recent years, mental health concerns have attracted greater attention among the constellation of health care priorities and are seen as a more significant component of overall health status and well-being. However, they still remain secondary to many other medical/surgical priorities. Over several decades, studies in a variety of countries have consistently documented inadequate treatment of all psychiatric disorders studied, especially depression.[1]

THE POLICY CHALLENGE

Several findings consistently emerge across studies. Depressive disorders are more disabling than other common medical disorders that policymakers take more seriously. Depressive and anxiety disorders are prevalent in most populations studied and their presence may be increasing, but only a minority of persons who report symptoms that meet the criteria for disorder receive treatment. In most countries, the majority of treatments—in the United States about half—come through the primary care sector or self-help and family support. Studies find poor recognition of these disorders by primary care physicians (PCPs), with usual estimates in the United States and

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This article is derived from the proceedings of the meeting "ESEMeD: Benefit to the Community in Depression and Anxiety," held on September 5, 2003, in Cliveden, Berkshire, United Kingdom. The meeting was supported by an unrestricted educational grant from GlaxoSmithKline Pharmaceuticals.

The author reports no additional financial or other relationships relevant to the subject of this article.

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Table 1. Treatment for Depression in the United States in 1987 and 1997[a]

Treatment	1987 (N = 223)	1997 (N = 775)
Pharmacotherapy, % patients	45	79
Antidepressants	37	75
SSRIs	0	58
Other	37	28
Benzodiazepines	16	10
Psychotherapy, % patients	71	60
No. of visits, mean	13	9
Psychotherapy and antidepressants, % patients	23	45

[a] Adapted from the Journal of the American Medical Association, Jan 9, 2002, 287(2): Tables 1 and 3.[6] Copyright 2002, American Medical Association. All rights reserved.
Abbreviation: SSRIs = selective serotonin reuptake inhibitors.

United Kingdom falling in the 50% range. When recognized, these disorders are commonly treated with inappropriate drugs, appropriate drugs at suboptimal doses, or not at all. Continuity of care is poor and care of even minimally adequate standards is not common. Those who have persistent symptoms over long periods and/or significant dysfunctions associated with their symptoms are more likely to be treated eventually, but often with long delays[1–3] (see also Lecrubier,[4] this supplement).

Since the 1950s, efforts have been made to raise the profile of depression and anxiety disorders among PCPs and to improve recognition and provide the most appropriate treatment available.[5] These efforts have occasionally had some effect in the short term but have had minimal overall success. As new drugs with fewer significant side effects and less risk have come onto the market, PCPs have become more comfortable prescribing these medications, and consequently there have been substantial increases in use over the past decade.[6]

Comparing data from 1987 and 1997, the proportion of the U.S. population treated for depression has increased more than 3-fold. Indeed, the rate per 100 persons increased from 0.73 in 1987 to 2.33 in 1997. Among those who received treatment, the proportion who received antidepressant medications increased from 37% to 75% (Table 1).[6] Selective serotonin reuptake inhibitors were not available in 1987, but by 1997 58% of patients received them. There were reductions in the proportion of patients receiving psychotherapy and a decrease in the use of benzodiazepines, while the proportion of patients receiving both psychotherapy and antidepressants almost doubled between the 2 periods. Thus, there is evidence of increased availability of treatment, but studies consistently find that treatment falls far short of guidelines or effective intervention.[1–3,7] Moreover, adherence by patients to many psychiatric drug regimens is poor and clinicians appear to lack understanding or good strategies to monitor or maintain adherence.[8] However, there have been indications that improvement in the quality of care for depression is being successfully achieved and that such care is cost effective.[9,10]

Initiatives to Improve Appropriate Help-Seeking, Recognition, and Treatment

The perception of high rates of psychiatric disorders in populations is a barrier in the minds of many policymakers to formulate policies that improve the accessibility of treatment. Perceived high rates, which are often confounded with concepts of need, give the impression that mental health care is a bottomless pit that, if encouraged, will substantially increase costs and pose significant budgetary challenges for public authorities as well as for other payers. Pharmaceutical drugs, including psychiatric medications, are a rapidly increasing proportion of expenditure in most countries and contribute to the growing proportion of gross domestic product devoted to health.[11]

There is a strong belief among some scientists and many policymakers that nosologic systems, and epidemiologic measures based on them, are overinclusive and that this undermines plausibility.[12] There is a compelling need to make a credible business case that disorders associated with limitations of function and with significant risks for health, productivity, and well-being can be appropriately and reliably identified among this larger population, and that systems can be put in place to triage such care responsibly so that it is provided appropriately and in a cost-effective way.

FACTORS INFLUENCING APPROPRIATE HELP-SEEKING, RECOGNITION, AND CARE

There are at least 4 sets of factors that can influence appropriate management of anxiety and depressive disorders: (1) patient factors, (2) health care provider factors, (3) societal factors and the media, and (4) health care organization and administration factors. In each case, health and other social policies can have significant effects in facilitating and supporting appropriate care.

Patient Factors

Much of the general population does not regard depression and anxiety disorders as illnesses or conditions appropriate for medical treatment.[13] Even the diagnostic labels themselves are not familiar to many people. Although the term *clinical depression* is widely recognized, few recognize the term *generalized anxiety disorder*.[14] Moreover, there is a dearth of understanding among the public about treatment possibilities for reducing associated distress. Acknowledging symptoms of disorder, even to the PCP, is stigmatized and many patients fear being labeled as having a mental illness.

Indeed, the terms *mental illness* and *mental disorder* are particularly stigmatized and the extent to which depression and anxiety are characterized using these or related terms may constitute a barrier to seeking and/or accepting treatment. Studies show that the public tends to associate the designation *mental illness* with psychotic, irrational, and violent behavior, and that the stigma associated with these behaviors remains high.[15] Some research suggests that patients who attribute their distress to a mental or psychiatric problem suffer greater decrements in self-esteem than those who view it as a physical or bodily illness.[16]

Many patients are reluctant to report psychological symptoms to doctors unless specifically asked, and many focus their complaints on the physical aspects of depression and anxiety. Patients reporting psychological distress to doctors are vigilant to cues of inattention or disapproval, and are easily diverted if they sense a lack of interest or attention.[17] Many patients view taking psychiatric medication as a sign of weakness, believing that overcoming symptoms is a matter of willpower and thus refusing treatment. When asked why they did not seek treatment many patients report that they wish to manage the symptoms on their own.[18,19] There are important cultural differences among population groups in their willingness to report depression and anxiety, the stigma they perceive to be attached to these conditions, whether they think presenting such symptoms to doctors is appropriate, how they believe family and friends would react to them being recognized as having such a condition, and their willingness to seek and accept treatment. These differences may vary according to education, acculturation, and/or experience.[13,20–22]

Insurance coverage for psychiatric visits and drugs is an important determinant of whether people seek care and how much care they use. In general, the health services literature in mental health significantly underestimates the importance of insurance because of poor measurement of insurance variables and other methodological shortcomings.[23] Studies of health insurance using more sophisticated measures find that use of mental health services is more responsive to insurance coverage than general health care.[24] Thus, insurance is an important enabling factor and central to initiatives to improve treatment effectiveness.

Various countries have carried out voluntary community screening for depression, although these efforts have not been carefully evaluated. One study of the 1994 National Depression Screening Day in the United States found that 57% of those recommended to seek treatment did so and 72% received a diagnosis of depression.[18] The most important reasons for not following up the recommendation to seek treatment were the belief that one could handle depression on one's own and problems with insurance coverage. The finding that persons who had previously received treatment were more likely to respond to the recommendation suggests that screening is more effective among those who have already overcome treatment inhibitions and less effective for previously untreated patients. Although cost-effectiveness analyses have not been done, such screening is relatively inexpensive and may be a useful adjunct to other policies to improve recognition and treatment.

Clinician Factors

PCPs vary in their interest and knowledge of psychiatric conditions. In many countries, the integration of psychiatry and other medical specialties is often inadequate. It should begin during medical training, but students commonly develop negative attitudes about mental health early, and such attitudes often persist. Having little training experience in treating psychiatric morbidity in primary care, doctors frequently feel uncomfortable in treating these conditions and tend to focus on and develop their expertise in treatments they are familiar with and feel comfortable providing.

In most countries, PCPs work under extreme time pressures with increasing expectations of what should be done during a medical visit.[25,26] Many complain of the burden of their workloads and burnout, and they commonly view patients with psychiatric conditions as adding to these demands. Doctors see themselves as too busy to question patients about psychosocial factors, depression, anxiety, and other life problems that may complicate and lengthen visits. Patients with psychological distress are commonly seen as "blockers" who slow the desired practice pace. Unless they have a special interest in psychiatry, PCPs give concerns about depression and anxiety a low priority, tending to be not overly attentive to the recognition and diagnosis of psychiatric disorders, and generally providing poorer quality care. Those who provide more comprehensive primary care or who have a continuing relationship with patients are more likely to inquire about depression.[27] Psychiatrists provide the most appropriate care for depression and anxiety disorders[3]; however, most patients have limited access to the mental health specialty sector, which public payers prefer to limit to the most severely ill. Often when such specialty care is available, patients are expected to pay for more of the treatment cost themselves, as in the United States.

Doctors are aware of the stigma associated with psychiatric disorders and may even share some of these stigmatized views. Furthermore, in some medical systems, doctors may compete for patients and are reluctant to suggest diagnoses and treatments that they believe patients will resist. Thus, doctors commonly "back off" when encountering patient resistance to psychiatric diagnoses or treatments; this is particularly common in the case of more elderly patients.

PCPs generally do not receive any rewards or recognition for interest in and good management of psychiatric conditions, beginning in medical school and growing as practice and time constraints make attention to such issues more difficult. Public authorities can do much to encourage better integration of psychiatric training in medical school and in promoting and rewarding continuing education in the treatment of psychiatric disorders. This can be done by recognizing outstanding quality care through merit awards or other forms of recognition and by establishing reimbursement arrangements that recognize the time and effort required to properly diagnose, treat, and monitor patients' psychiatric conditions.

Societal Factors and the Media

Stigma, as already noted, remains a major disincentive to acknowledge psychiatric illness and accept treatment, particularly from the specialty mental health sector and psychiatrists. Public perceptions and attitudes can be modified over time by effective media coverage. However, attitudes are slow to change and are often more dependent on input from family and peers than impersonal media-driven communications. Many consumers dismiss advertising; however, serious, informative, and easy-to-understand coverage can contribute to public understanding and acceptance.

Personal testimonies about their disorders and effective treatment by highly respected and esteemed public figures such as officials, popular entertainers, athletes, and scientists can be powerful contributors to public knowledge and induce people to seek care. Experience and research show that media discussion of illnesses by respected high-profile individuals (such as Betty Ford, Rock Hudson, Tipper Gore, and Magic Johnson) increased awareness and were followed by upsurges in help-seeking. For example, the publicity surrounding the breast cancer diagnosis of Betty Ford, wife of the U.S. President, appeared to substantially increase screening and the diagnosis of breast cancer.[28] Having such persons involved in educational activities can be useful, and such efforts are now routinely made by the National Alliance for the Mentally Ill in the United States. However, such organizations communicate to select audiences and their association with mental health probably limits the extent of their impact. Pursuing this objective through broader organizations, not specifically designated as mental health organizations, may have a greater appeal and reach more people. The public takes great interest in the private lives of celebrities and is more attentive than it would be to other forms of information. It is important for the public to understand that the communication is sincere and voluntarily motivated; knowledge that the individuals are reimbursed for their contribution may significantly reduce any positive effect.

Although media can have an influence, studies repeatedly show that immediate social networks, including relatives, friends, coworkers, and neighborhood groups, are more trusted and ultimately more influential. This peer factor has been found to be significant in decisions by professionals to adopt recent innovations, including new drugs.[29,30] Personal encouragement from "trusted others" who are seen as having no ulterior motivation can be very powerful. Knowledge that relatives and friends, and their friends and relatives (sometimes called "social circles of friends and supporters of psychiatric treatment"), have benefited from treatment can be extremely helpful.[31]

The public stigma associated with terms like *mental illness*, *mental disorders*, and *psychiatric illness* can be a disincentive to treatment. Disassociation of the treatment of depressive and anxiety disorders from these concepts, and presentation of these problems in alternative ways, may offer opportunities to reduce this stigma.

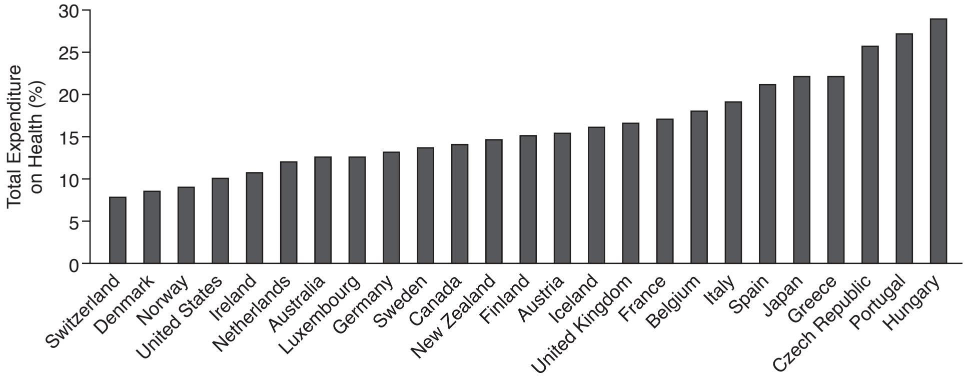
One way of informing the public of the treatments that may be relevant to their disorders is direct-to-consumer advertising, which is currently only a small component of drug advertising in the United States but has been growing. The social value of such advertising is strongly debated and there is much concern that it increases demands on physicians, leads to excessive use of drugs (particularly more expensive ones), and contributes to escalation in health care costs. An argument for direct advertising is that it introduces patients to treatments they may not know about. Direct-to-consumer advertising has not been accepted by the Organization for Economic Cooperation and Development (OECD) countries, but selected forms of generic advertising to bring public attention to the fact that effective treatments are available for anxiety and depressive disorders could be helpful. Such public-service advertising might be financed by consortia of pharmaceutical companies, by government agencies, or through cooperative agreement. In the United States, the National Institute of Mental Health sponsored the DART (Depression Awareness, Recognition, and Treatment) campaign to carry out such public-service advertising, but unfortunately the program has not been rigorously evaluated.

Health Care Organization and Administration Factors

Many governments are concerned with growing health expenditure and the need to allocate resources efficiently. The growth of pharmaceutical costs relative to other medical care components makes these concerns an increasing focus of attention. Many factors affect the use of pharmaceutical drugs among countries, such as culture and traditional practices of the health care system, coverage and reimbursement, and the various regulations that influence the behavior of patients, doctors, and pharmacists. Figure 1 presents OECD data for a number of countries, showing the expenditure for pharmaceutical drugs as a proportion of total expenditure on health.[11] Such percentages range from < 10% in some Scandinavian countries to > 25% in some of the poorer countries in Europe. There is considerable range among the European countries, including those covered by the psychiatric European Study of Epidemiology of Mental Disorders (ESEMeD) surveys. Pharmaceutical expenditures per capita depend on per capita gross domestic product, and such expenditure is particularly high in France, Japan, and the United States.

There is a wide variety of strategies used by health systems to control the growth of pharmaceutical costs, from research and development, production incentives,

Figure 1. Expenditure on Pharmaceutical Drugs as a Percentage of Total Expenditure on Health, 1997[a,b]



[a] Reprinted with permission from OECD.[11]
[b] Data are for 1997, except for Norway, Ireland, Australia, Luxembourg, Japan, Greece, and Hungary (1996).

and drug approval procedures to decisions about coverage, reimbursement, and distribution.[11,32] Countries maintain formularies that exclude some drugs from reimbursement and highly control access to others, while demand is regulated by coverage rules and cost sharing, including the use of coverage thresholds (deductibles). Most countries either encourage or require the use of generic drugs when available or substitution of less expensive for more expensive medications. Controls may be applied to pharmacist reimbursement or even the location of pharmacies. In the United States, complex pharmacy benefit management programs are common, with tiered cost sharing depending on the type of medication involved.

A range of strategies is used to control the ways doctors prescribe. In fundholding practices in the United Kingdom and in some health maintenance organizations in the United States, doctors' budgets (or capitation payments) may include pharmaceutical costs and some proportion of savings can be returned to the practice. In other countries, there may be financial incentives for doctors to meet established prescribing targets, or there may be direct limits on prescription budgets or the quantity of drugs prescribed per day or per episode. Increasingly, countries have prescribing guidelines including specific approval procedures for reimbursement for some prescribed drugs.

The National Health Service in the United Kingdom has long monitored prescriptions by general practitioners and visited doctors who are outliers. Although such visits have been described as educational, they have been much resented by doctors. In the United States, most health insurance benefits for depression and anxiety and other similar disorders are managed by behavioral health organizations. Medications may also be part of such plans, or they may be excluded and managed separately. Management may involve ascertaining the need for the intensity of service, high-cost case management, determining the required period of care, generic and brand name prescriptions, and substitutions among types of care and treatment personnel.

Many countries have elaborate regulatory procedures for approving new drugs or additional uses of approved drugs. Pharmacoeconomic assessment is increasingly common in both public and private health plans. The OECD reports that such assessments are spreading among member countries and are a useful decision-making tool.[33] Although such assessment of value for money is motivated by cost considerations, if done properly it may provide a pathway for encouraging more use of drugs that presently are inadequately utilized.

One such organization that provides public guidance in the United Kingdom is the National Center for Health and Clinical Excellence (NICE), which provides patients, professionals, and the public with guidance on best practice. Good practice requires attention to the underuse of effective therapies as well as their overuse or misuse and may increase overall cost. It is difficult to believe that NICE assessment, if performed with integrity, will not increase the costs of prescription drugs for undertreated psychiatric disorders in the aggregate over time. The work of NICE is controversial and is contested by both free-market advocates and those on the opposite side who seek more stringent rationing decisions. It is likely that NICE recommendations can increase medical care costs, e.g., in 2002, NICE recommended that the use of newer atypical antipsychotic drugs for schizophrenia should be considered as first-line treatment for newly diagnosed patients.[34] NICE has just reviewed new drugs for bipolar illness and the treatment of depression in primary and secondary care. However, NICE is of course cost conscious and, in the case of the atypicals, notes that "when more than 1 atypical antipsychotic drug is considered appropriate, the drug with the lowest purchase cost (taking into account daily required dose and product price per dose) should be prescribed."[34]

POTENTIAL APPROACHES TO FACILITATE APPROPRIATE CARE

As the foregoing review should make evident, achieving more appropriate help-seeking recognition and treatment for depressive and anxiety disorders is a multifaceted challenge not likely to be achieved through any single initiative or strategy. Various aspects of achieving appropriate care require different policy initiatives and players, which should be aligned in common directions.

Efforts should be made to achieve some consensus, with empirical support, on reasonable criteria to determine the treatment for those with depressive and anxiety disorders. Such a consensus should include easy, measurable, and reliable disability indicators, and evidence that treatment of patients with varying levels of need (as defined by these criteria) is cost effective. Good criteria must be clinically interpretable, meaningful, and not simply a quantitative measurement (e.g., many physicians have difficulty making clinical sense of the differences indicated by the Short-Form Health Survey [SF-36]). Measures used must demonstrate clinically meaningful reductions in distress/disability and have an impact beyond reducing short-term indisposition. Advocates should work with various public agencies in developing these criteria.

Better information is needed on the relationship between pharmaceutical interventions and coping effectiveness. It is commonly argued that medication is a substitute for coping meaningfully with life difficulties and challenges. It is equally plausible, however, that medical treatment facilitates improved coping and coping effectiveness.

Efforts should be made to encourage governments and other policymakers to provide appropriate coverage for access to primary and secondary care, the treatments required, and sufficient resources so that care is available when needed. Since there are strong barriers to treatment, policymakers might consider inducements to care, such as eliminating co-payments for specified cost-effective services and reducing distance barriers and waiting times.

Consideration should be given to treating depression and anxiety using terms other than *mental health* and *mental illness*. Attempts to enlist national public-interest organizations concerned with constituents' health in informal programs should be encouraged. In the United States, such organizations might include the American Association of Retired Persons, the League of Women Voters, or the Consumers Union.

Endeavors to work through community and friendship groups, such as neighborhood organizations or peer work groups, should be made to bring personal information about depression and anxiety to their associates. Public grants may be made for organizing such groups and enlisting schools, churches, unions, news media, and other organizations in these efforts.

Professionals providing services for those suffering from depression and anxiety should be reimbursed at the same time, effort, and expertise levels as those providing other medical services. Further financial incentives should be considered in encouraging interest in addressing these disorders.

Doctors and managers should be encouraged to address the problem of depression and anxiety by including indicators of good treatment through quality-assurance efforts and rewarding high quality. Similarly, they should provide support for nurse practitioners, social workers, and psychologists to work with PCPs and adopt information technology approaches for successful monitoring and management of these conditions. A major challenge is to incorporate these efforts within the realistic constraints of primary care, and computerized disease-management programs can be of value. Finally, current medical and postgraduate education relative to the management of such conditions should be reviewed.

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