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Exploring Cancer Screening in the Context of Unmet Mental Health Needs: A Participatory Pilot Study

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Abstract

Background—Cancer is the leading cause of preventable death in the Bronx, New York. Service providers in this mental health provider shortage area identified untreated mental illness as an important barrier to participation in cancer screening, a finding that supports existing literature. The Mental Health and Cancer (MHC) Connection partnership formed to investigate and address this issue.

Objectives—We sought to use an ecological framework to examine barriers and facilitators to obtaining mental health services in the Bronx, and to explore how lack of access to mental healthcare affects cancer screening.

Methods—In this community-based participatory research (CBPR)-driven pilot study, semistructured, qualitative interviews based on an ecological framework were conducted with 37 Bronx-based service providers representing a range of professional perspectives. Data were analyzed using thematic content analysis and techniques from grounded theory.

Results—Similar barriers and facilitators were reported for mental healthcare and cancer screening utilization across ecological levels. Providers emphasized the impact of urban poverty-related stressors on the mental health of their clients, and affirmed that mental health issues were a deterrent for cancer screening. They also recognized their own inability to connect clients effectively to cancer screening services, and rarely saw this as part of their present role.

Conclusions—Findings highlight how unmet mental health needs can affect cancer screening in impoverished urban contexts. Participants recommended improving linkages across healthcare and social service providers to address mental health and cancer screening needs simultaneously. Study results are being used to plan a collaborative intervention in the Bronx through the MHC Connection partnership.

Keywords

Mental health; cancer screening; health service use; qualitative methods; partnership; community-based participatory research

Bronx County, New York, is the poorest urban county in the United States.[1,2] Cancer is the leading cause of premature death in the Bronx, with lung, prostate, and colorectal cancers accounting for the highest mortality among men, and lung, breast, and colorectal cancers accounting for the highest mortality among women.[3,4] Although screening has been shown to reduce death from three major cancers—colon, cervical, and breast—many individuals still experience barriers to participating in age-appropriate screening, treatment, and follow-up.[5] Underserved populations across the United States are significantly more likely to be diagnosed with preventable and late-stage cancers than the general population and to experience barriers to screening.[6,7] In the Bronx, these barriers are not necessarily related to screening access; free or sliding scale cancer screening services are available regardless of insurance or immigration status through New York City's Health and Hospitals Corporation, Federally Qualified Health Centers (FQHC), and the Bronx Cancer Services Program.[8–10] One potential barrier to timely cancer screening among medically underserved populations that needs further exploration is the impact of unmet mental health needs on screening behavior.

This question is of particular relevance in counties like the Bronx, where data indicate significant unmet mental health needs. In city-wide surveys, some underserved Bronx neighborhoods report rates of severe psychological distress nearly twice that of more affluent Manhattan neighborhoods,[11] and roughly half of the Bronx is designated a Mental Health Professional Shortage Area.[1] Moreover, areas in the Bronx with the highest rates of severe psychological distress and hospitalization owing to mental illness are also the areas with the greatest shortages of mental health professionals.[11] Previous research, predominantly within single-payer healthcare systems, suggests this shortage could have serious implications for cancer screening, treatment, and mortality.[12–20] However, in the United States, few studies have examined the relationship between access to mental health services and patient adherence to cancer screening recommendations, particularly in medically underserved, poor communities such as the Bronx.[21–23]

To address this research gap, we designed the MHC Connection pilot study to identify, within an ecological framework,[24] the barriers and facilitators to accessing mental health services and cancer screening in the Bronx. Our purpose was to understand how insufficient mental healthcare affects use of cancer screening services and to build a sustainable partnership for improving cancer screening among those with mental health needs. The MHC Connection uses a community-based participatory research (CBPR) approach that brings together the expertise of Bronx community members, service providers, and academic researchers. Tackling complex systemic health disparities necessitates a strong, multisector partnership,[25] and a CBPR approach creates a platform for communities to work with university partners to identify and address the social, economic, and environmental factors that have an impact on their lives.[26] This paper describes the qualitative methods and

findings from the MHC Connection study, including implications for the partnership, limitations, and directions for future research.

METHODS

Creation of the MHC Connection Partnership

In Spring 2009, staff and faculty from the Albert Einstein Cancer Center's ("Einstein") Community Assessment and Capacity Building Core (the "Core"), began to reach out to community-based organizations (CBOs) that provided direct services to residents of the Bronx, such as job training, housing support, legal assistance, religious counsel, foster care prevention, and medical care. The Core was a newly established resource at Einstein, focused on supporting the development of community academic partnerships and CBPR studies to improve cancer prevention and control in the Bronx. After Core staff met with more than 20 organizations, a recurring theme emerged: From providers' perspectives, the lack of mental health services and its consequences were more pressing issues than cancer screening for Bronx communities. Consequently, we began to review the literature for information about the relationship between mental health and cancer. Based on the findings of the review, we re-contacted community agencies that had expressed concern about both mental health and cancer screening in the Bronx, and asked if they would be interested in collaborating on a grant proposal to address the two issues simultaneously. Six CBOs participated in the submission of a pilot grant in September 2009 to the Einstein-Montefiore Institute for Clinical and Translational Research. These organizations were eager to work together, in part because their services were complimentary and they saw partnering as a way to strengthen and build new relationships that would help them to better serve their clients (Figure 1).

Funding was awarded in December 2009, and a new partnership (MHC Connection), composed of Core faculty and staff and representatives from the six CBOs, was formalized. At the first official partnership meeting, the group established a protocol for making decisions by consensus, ensuring that every partner had a voice in the project development and implementation. Task delegation and responsibilities were agreed upon at the end of each meeting. Partners volunteered to contribute based on time and expertise available. Every effort was made to equitability distribute tasks. However, the staff who were assigned to the project, including a graduate research assistant, a community research assistant, and a project coordinator, had primary responsibility for carrying out data collection.

Design and Sample

The partnership decided to use semistructured interviews with providers in the community to identify the intrapersonal (individual), interpersonal, organizational, community and policy, or societal[24] barriers and facilitators to accessing and utilizing mental health and cancer screening services in the Bronx. The goal of this ecological perspective was to understand the relationship between unmet mental health needs and cancer screening behavior. Although the partnership recognized the potential value that in-depth interviews with individuals experiencing barriers to mental health treatment would provide, community partners suggested that, because of the lack of immediately available, affordable mental

health services for participants in need, they felt that conducting such interviews would be unethical. Community and academic partners collaboratively developed a guide for interviewing service providers based on the research literature and personal experience serving clients.[18,19,21,22,27–30] The guide was composed of structured, yet open-ended questions about mental health and cancer screening access and utilization. Specific question areas included referral networks and sources of information, perceived capacity of services and settings, insurance and other financial barriers, perceived stigma around mental health and cancer, social networks' influence on the use of mental health and cancer screening services, mistrust of medical providers, and transportation issues, particularly for older patients. Community partners also felt it was important to gather data about the providers' views on clients' utilization of general preventive health services, so the guide included additional open-ended questions to cover this topic.

Service providers were eligible to participate in the study if they worked at an agency serving Bronx residents and were familiar with adult mental health, cancer screening, and/or preventive care issues. Sampling criteria were broad to capture a wide range of experiences in connecting clients to both mental health and cancer care from various service settings. Sampling occurred in two stages. First, our six community partners identified an initial purposive sample of ten participants from within their agencies; respondents inter-viewed from these partnering agencies did not report to the partnership representatives. Next, snowball sampling, where each respondent was asked to recommend other individuals for the interview, was undertaken to identify participants in three key stakeholder groups: (1) Medical service providers,[31] (2) mental health service providers, and (3) individuals representing social services and faith-based organizations. To ensure a heterogeneous sample, we contacted no more than five referrals from each source.[32] Typically, sources generated only one or two referrals, except in the case of a few highly connected individuals. Sometimes, more than one participant was interviewed from the same agency because of their different perspectives and expertise. Ultimately, our partnering organizations were reflective of the types of organizations in the sample as a whole.

Interviews took place during the summer and fall of 2010. Sixty-four individuals were approached to participate in the study. Research staff directly contacted potential participants via phone and/or email, reaching out to each individual up to three times. In total, 37 individual interviews were completed from 27 organizations, including foster care and family assistance agencies, religious organizations, senior services agencies, legal service providers, schools, housing agencies, and healthcare providers. Twenty-three of the 64 individuals approached could not be reached initially or did not respond to follow-up, and four declined owing to lack of interest, institutional policies against participating in research, or scheduling conflicts. Interviews lasted, on average, 75 minutes and most were conducted at respondents' offices. Table 1 describes the demographic characteristics of the sample.

Community partners assisted staff in reaching providers as necessary. Participants were compensated $40 for their time. Data collection concluded when the partnership members agreed that thematic saturation, defined as the point where the data become repetitive and no new information was gained from newly sampled individuals, was reached.[33] The study was

reviewed and approved by the Albert Einstein College of Medicine Institutional Review Board in May 2010.

Data Analysis

Qualitative Approach—Qualitative data were analyzed using thematic content analysis, a qualitative approach to content analysis that draws on the strengths of both thematic analysis and content analysis. It is considered an ethnographic technique and is recognized as a respected method for discerning themes of meaning in text.[34,35] Unlike traditional content analysis, in thematic content analysis various units of text (such as a word, sentence, or paragraph) can be associated with more than one theme or code.[34] In thematic content analysis, although code and theme counts can be elicited, the focus of the analysis is on interpretation and meaning and goes beyond numeric frequency.[34,35] The decision to utilize grounded theory procedures in addition to thematic content analysis was driven by our community partners' interest in considering alternative meanings of the phenomena that were the focus of the study, as well as their desire to build rather than test a theory.[36,37] Thus, combining these two qualitative methodologies for analysis enabled our community and academic partners to work together to develop a coding scheme guided by the ecological framework as well as to allow a narrative to emerge from codes and themes.

Process of Analysis—Recorded interviews were transcribed by the community research assistant and organized using NVivo 9.0 software. Transcripts were reviewed by the graduate research assistant and the Core coordinator (both of whom had conducted the interviews) to identify key issues.[38,39] Open coding techniques from grounded theory were utilized to develop the initial code book,[40,41] and a draft codebook was developed that included the code, the code's definition, and a sample quote. This was then presented to the partnership for discussion and validation, along with illustrative quotes from interview transcripts. Codes were refined and added based on the partnership's discussions. The codebook was finalized via group consensus. Using thematic content analysis, all interviews were then systematically coded using the final codebook by four project staff (the graduate research assistant and Core coordinator mentioned, as well as the community research assistant and the Core manager). To ensure a high degree of consistency across coders, these four staff used the codebook to analyze a subset of the transcripts and then compared coding; consensus was reached when differences existed.[42] At several points, the partnership convened to review the coding process and to discuss the preliminary results. During this iterative process, a number of codes were further parsed into subcodes to address specific study aims and concerns raised by the group. When transcript coding was completed, the content of all text associated with each individual code was synthesized and presented as a narrative to the partners. The partnership then considered how this narrative related to the ecological framework,[24] to identify optimal targets for intervention.

RESULTS

We first present an overview of the barriers and facilitators to utilization of mental healthcare and cancer screening services that respondents perceived to be most important, as well as how these facilitators have, in respondents' experiences, offset some of the key

barriers. We next describe the two most salient themes from the data that help us to understand the relationship between mental health needs and cancer screening: The interplay of mental health and social issues that impede cancer screening, and cancer screening as a lost priority among providers.

Barriers and Facilitators to Accessing Care

Providers reported extensive barriers to accessing mental health and cancer screening services in the Bronx, as well as various programs and other kinds of facilitators that have been able to address these barriers for some individuals and in some locations. Although providers were asked about barriers and facilitators to mental health and cancer screening services separately, the barriers and facilitators they described overlapped so greatly that they are described simply as barriers and facilitators to healthcare (see Table 2 for the most salient barriers and facilitators mentioned, placed within the ecological framework).[24] Despite the prevalence of major barriers to care for the Bronx population, providers interviewed reported a number of success stories about how some of the barriers at different ecological levels have been offset by one or more facilitators.

For example, at the policy level, although federal immigration policy leads individuals to fear utilizing the healthcare system and prohibits undocumented immigrants from getting Medicaid, within the Bronx, the existence of FQHCs, the New York City public hospital system, as well as funding from the Centers for Disease Control and Prevention for cancer screening have enabled undocumented immigrants to obtain cancer screening. In addition, mental healthcare is available at a number of FQHCs regardless of immigration status.

Nonetheless, the availability of these services was not widely known among respondents from the social service sector. These types of policy-level barriers and facilitators were most frequently mentioned by respondents working in the legal and medical care delivery sectors. At the organizational level, some respondents described how poor continuity of care is being improved through the movement toward integrated models of care, which co-locate mental health and medical services. This type of facilitator was emphasized by respondents who worked in health centers. At the community and interpersonal levels, a number of respondents reported how their social service agencies have been working to mitigate the stigma associated with receiving mental healthcare by building group mental health services into other kinds of social service programs, such as games and activities for seniors that provide a comfortable way for discussing concerns, issues, and problems they encounter. Additionally, as some medical providers described, patient navigator programs and educational outreach funded by New York City and the American Cancer Society have made inroads in destigmatizing cancer screening in the Bronx. At the individual level (intrapersonal), many social service and medical providers commented that tapping into parents' desires to be a better parent and healthy for their children can motivate parents to prioritize mental healthcare and to undergo cancer screening.

Mental Health and Social Issues that Impede Cancer Screening

Interviews revealed substantial interplay between mental health and social issues often associated with urban poverty and related stressors. These issues often impeded individuals'

ability to practice important preventive health behaviors like cancer screening. When respondents talked about mental health, they were primarily referring to depression, anxiety, chronic stress, and responses to trauma. They suggested a definition of mental health that includes the impact of environmental-level stressors in poor urban communities such as the Bronx. They also noted that mental health problems and social issues shared common causes, namely lack of resources and opportunity. One provider summarized the interaction of these issues:

> It's a cycle. They're depressed or stressed because they don't have the money. They live on a fixed income and then they have all these environmental factors: Their building is unsafe; there's drugs or it's noisy; the super won't come and fix anything. . . . I think a lot of the mental health issues that happen are because you live in a low-income environment and it affects you. I don't think I can think of anyone who really struggles financially and it doesn't push them to the edge.

As this provider implies, a number of key social issues emerged as having an important interaction with mental health, and an indirect impact on cancer screening. These included substance abuse, immigration stress, housing issues, difficulties navigating the system, unemployment and underemployment, interpersonal violence, and incarceration (Table 3). Providers also emphasized that discussing mental health problems as "stress" would resonate more with clients and residents more broadly than traditional, and more stigmatizing, mental health terminology such as "mental illness," "depression," or "anxiety." In validation of these findings, the partnership confirmed that the intersection between mental health and these social issues resonated with their experience in the field.

Cancer Screening: Provider Knowledge and Attitudes

Despite the burden of cancer in the Bronx and the partnership's interest in this topic, cancer screening was generally not viewed by providers as a part of their organization's present mission, which typically focused on meeting clients' basic, immediate needs. This was true for social service providers as well as some medical providers. When asked about his agency's involvement with cancer screening services, one medical provider explained:

> Preventive healthcare services are usually not my top priority when someone comes to see me. If I get involved in a big discussion about domestic violence or something else … it's kind of hard to say, "Okay, now I'm going to refer you for your colonoscopy."

Providers who worked in agencies that do not provide healthcare often did not know how to connect patients with screening services, and some expressed confusion about screening guidelines and the purpose of particular screening tests. Although few medical and social service providers considered cancer screening referrals a priority, participants generally recognized the value of screening tests, and many shared anecdotes of family members and clients who had been affected by cancer. One provider who worked in a public defender's office told the story of a former client, whose later untimely death from cervical cancer demonstrated the importance of improving cancer prevention in the Bronx:

> I had a client who was undocumented and did not have health insurance here in the Bronx. . . . After she gave birth to her youngest child, she was . . . experiencing a

> number of symptoms, and she went back to that clinic several different times and was told she was fine and that it was postpartum symptoms.... She went back for a period of about 8 months repeatedly and never got an exam. . . . They finally did a Pap smear, and by the time they got the results, they sent a nurse over to her house to take her straight to the hospital because she had stage four cervical cancer.

Thirty-one of the 37 providers reported that they considered cancer screening one of the most important issues to address in the Bronx, even though neither they nor their organization emphasizes it to clients. In addition, most providers believed that individuals with mental health issues are less likely to get screened for cancer. When providers were asked whether they thought mental health issues affect participation in preventive healthcare, they mentioned that stress and depression in particular often decrease clients' motivation to seek care. One provider commented:

> So when people are in crisis . . . health tends to become much less important for them as opposed to dealing with crisis. So for people whose minds are preoccupied by anxiety and a chaotic life, it's difficult for them to find the space, time, resources to engage in preventive healthcare behaviors.

Providers' observations supported prior research findings that untreated mental illness makes individuals less likely to undergo age-appropriate cancer screening. Our data indicate that the reasons for this appeared to be two-fold in the Bronx: Mental illness made providers less likely to recommend cancer screening, and individuals with untreated mental illness were less likely to seek cancer screening. Both providers and the individuals they served were, out of necessity, focused on dealing with crisis-driven concerns. Nonetheless, providers pointed to opportunities for improving cancer prevention and control by enhancing linkages between existing crisis response services, and programs providing cancer screening. In fact, discussions of linkages and integrated services were important themes that emerged when participants were asked for suggestions about how we should move forward in addressing both mental health and cancer screening in the Bronx.

DISCUSSION

These findings support the premise of the MHC Connection project and previous studies showing that untreated mental illness discourages participation in age-appropriate cancer screening.[21,27,43–45] A key contribution of this work is that, through the use of qualitative methods, it begins to explore the underlying mechanisms behind inadequate cancer screening in individuals who do not receive needed mental healthcare. Our respondents described vividly how an individual's poor mental health leads to difficulty managing many life demands and to the inability to pay attention to one's own health needs, including cancer screening. Our findings also suggest that, in the Bronx, cancer screening becomes a lost priority as providers with limited resources work to connect individuals living in poverty with services to address more crisis-driven needs. The barriers identified in our results revealed that most providers did not know about free and low-cost cancer screening options in their neighborhoods. FQHC and Health and Hospitals Corporation hospitals throughout the county offer screening to residents regardless of immigration or insurance status.[9,10] The fact that providers and their clients did not know of these options shows that lack of

information among providers and patients alike creates an additional barrier to timely cancer screening.

As prior studies of barriers to cancer screening have shown, improving access is necessary but not sufficient to increase cancer screening rates. Attention needs to be paid to improving connections between social and medical service providers as well as to individual-level barriers often associated with race, poverty, and structural inequalities.[46–52] Among study respondents, there was general consensus that chronic stress and untreated mental health problems present substantial barriers to participation in age-appropriate screening. This consensus existed despite the varying perspectives of respon-dents working in different sectors (medical, social service, legal, housing) and at different ecological levels (policy, organizational, community, interpersonal, and individual). Thus, our qualitative findings underscore the interactive relationship between mental health and many other social issues that must be considered to effectively address disparities around mental health and cancer screening. Of particular importance were the effects of chronic life stress on mental health.[53–55] The academic partner's conceptualization of "mental health" evolved over the course of data collection, as it became apparent that, from providers' perspectives, the consequences of stress were directly linked to diagnosable anxiety, depression, and posttraumatic stress disorders for Bronx residents. Our participants emphasized how daily stressors, such as income instability, exposure to violence and other crime, inadequate and/or unstable housing, and immigration issues all contribute to poor mental health for many Bronx residents. These findings of the impact of poverty-related stress on mental health are consistent with previous quantitative work that has found poverty and unemployment in New York City to be strongly associated with severe psychological distress.[56]

The prominent role that life stressors play in mental health in the Bronx has important implications for multilevel intervention development. Specifically, any successful intervention to improve cancer screening among those experiencing untreated mental illness must carefully consider these life stressors, while fully leveraging partners' existing social service programs, as well as the low-cost cancer screening programs mentioned. In addition, the results of this study suggest that interventions to improve cancer screening among people with mental health needs must take into account the structural barriers (e.g., lack of adequate insurance, lack of transportation, clinic hours) that underlie both the relatively low rates of cancer screening and unmet mental health needs among individuals in the Bronx. The partnership is now working collaboratively to write governmental and foundation grants to obtain funding for one or more interventions that could address existing needs on multiple levels (intrapersonal, organizational, and community) while building capacity to deal with the shortage of services. This process, as well as partnership members' regular participation in meetings over the last 2 years, has served to strengthen linkages and referral systems between member organizations. This has, in itself, been a valuable outcome of the project and has laid the foundation for sustainability of future efforts.

Implications for Future Research

Although the connection between mental health and cancer screening was clearly described by providers in this study, the perspective of the individuals experiencing mental health problems and their decisions about cancer screening remain lacking in the literature. Future studies should explore this connection in a context where it is possible to connect individuals more easily with mental health services. In addition, research is needed to identify interventions capable of improving access and participation in mental health services in a manner that also facilitates age-appropriate cancer screening and other preventive health behaviors, particularly in resource-poor contexts like the Bronx. One approach that is now being explored by the MHC Connection Partnership is to create linkages between social service providers and FQHCs that offer cancer screening, as well as mental health article 28 clinics, which can be accessed when a mental health need is identified in primary care. The partnership is presently working to identify ways to make such linkages sustainable, and to provide the necessary support to individuals to enable them to follow through with medical appointments and treatment recommendations. This will serve as a timely complement to the current shift among most Bronx clinical networks to become patient-centered medical homes, in which a physician coordinates a team of medical professionals to provide optimal, integrated care for each patient.[57,58]

Limitations

There are four key limitations to this study. First, our inter view sample includes service providers who were predominantly female, reside in the Bronx, and work in CBOs. Second, because we asked respondents to provide their professional viewpoints, they may have described health and social problems in the Bronx largely from their professional lens and less from the perspective of their clients or from their personal experiences, if they were Bronx residents. This could have led them to emphasize certain difficulties or not mention others. Nonetheless, service providers were able to offer valuable information for the development of an ecological model, because of their experiences interacting with individuals, families, the larger Bronx community, and the systems and policies that support or hinder their work. Third, it is possible that some respondents, by virtue of the nature of their work, would not be expected to provide clients with information about cancer screening. Consequently, they may have spoken to us more hypothetically than from their actual professional experience. Last, we did not interview clients with mental health problems who are served by the organizations represented in the study, owing to the ethical concerns discussed. This is both a limitation of the present study and an important direction for future study, as noted.

CONCLUSION

Consistent with MHC Connection's ecological framework, our findings underscore how untreated mental health issues have multiplicative repercussions on the lives of Bronx residents, including their ability to receive cancer screening and other preventive care. Service providers emphasized that owing to the crisis-oriented needs of their clients, cancer screening is often treated as a low priority by health and social service providers, as well as by clients themselves. These findings suggest that any attempt to address these health

disparities must take into account the environmental-level stressors particular to a resource-poor, urban environment. Our work going forward with the partnership will focus on designing a multilevel intervention that focuses on individual and system-level barriers to care. Thus, we will consider the poverty-related determinants of mental illness, and work to increase access to and utilization of mental health services and age-appropriate cancer screening by increasing linkages among different types of services.

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Figure 1.
Placement of MHC Partnering Organizations' Services Within an Ecological Framework

Table 1

Sample Demographics

Bronx Service Providers	***N* = 37**
Age (yrs)	
Mean ± *SD*	44.7 ± 11.7
Range	23–68
Gender	
Female	27 (73.0%)
Male	10 (27.0%)
Self-identified race/ethnicity (responses are not mutually exclusive)	
Asian	3 (8.1%)
Black	7 (18.9%)
Hispanic	16 (43.2%)
Other	5 (13.5%)
White	17 (45.9%)
Refused	4 (10.8%)
Residency	
Bronx resident	22 (59.5%)
Non-Bronx resident	15 (40.5%)
Professional category	
Direct service provider	31 (83.8%)
Administration only	6 (16.2%)
Education	
GED	3 (8.1%)
Associate degree	1 (2.7%)
BS	6 (16.2%)
MA	7 (18.9%)
LMSW	2 (5.4%)
MSW	10 (27.0%)
MD	4 (10.8%)
PhD	3 (8.1%)
Missing	1 (2.7%)
Organization type	
Community-based organization	20 (54.1%)
School	2 (5.4%)
Faith-based organization	2 (5.4%)
Government office	2 (5.4%)
Hospital	7 (18.9%)
Medical practice or clinic	4 (10.8%)

Bronx Service Providers	***N* = 37**
Number of years at agency	
Mean ± *SD*	9.6 ±8.2
Range	1–30

Table 2

Barriers and Facilitators to Accessing Mental Health Care and Cancer Screening in the Bronx

Level[a]	Barriers	Facilitators
Public policy regulation and laws	Poverty, mental health reimbursement rates and insurance policies limiting access to care, immigration policy, inconsistent funding priorities	Government funding at the federal, state and local levels for initiatives aimed at reducing health disparities, such as federally qualified health centers, and the New York State Cancer Services Program, the New York City public hospital system; insurance company efforts to enroll patients
Community	Lack of providers, lack of referral sites, limited transportation, distance to clinics	Efforts of community-based organizations to provide accessible, high-quality services and information about and links to healthcare; programs by advocacy organizations and patient navigators to educate about cancer and benefits of screening
Organizational and Institutional	Waiting lists, clinic hours, high caseloads, poor continuity of care	Well-trained frontline social service and medical staff medical provider support to patients, partnerships between hospitals and community-based organizations, integrated models of medical care that include both mental health and preventive care, integration of mental health services into other kinds of social service programs
Interpersonal	Stigma, competing family priorities, interpersonal violence, medical mistrust	Existing social networks, trust of social service agencies
Individual	Lack of insurance and other insurance barriers, competing priorities and responsibilities, work schedule, lack of mental health awareness, low prioritization of self-care, language barriers	Motivation to be a better and healthier parent, interaction with the legal system

[a] these categories are based on the social ecological model.

Table 3

Illustrative Quotes About Social Issues

Issue	Quote
Substance abuse	"If you have mental illness and you're not taking care of yourself and if you self-medicate with a drug that's deteriorating your brain and body-your whole being-then that's going to cause something else."
Immigration stress	"People who have severe mental illness and are not institutionalized need a lot of social support which really is not there. Particularly if they're an immigrant and don't speak English and again if they have an educational disadvantage."
Housing	"With our adults, a lot of the issues impacting them are [related to] quality of living. Many of our families are living in very poor, unkempt buildings, and there's a sense of frustration at not being able to provide better for their children as well as fighting the system to get repairs done in the home."
Difficulties navigating the health system	"Because the majority of clients, they're not aware of the services, they're not aware of where they can go. Those who do [know where to go], maybe after a while, feel like they do need some help: 'How can I advocate for myself? What do I do when I get there? What will I say?'"
Unemployment and underemployment	"If people are mentally well then they can cope with adverse life events and they can cope with chronic stress. I think investing in a community . . . is going to lead to less chronic stress and a better living environment with people that are developed to their fullest capacity because they have employment, and they can provide for themselves and their families."
Interpersonal violence	"People that have a history of trauma or abuse or intimate partner violence . . . that's where people start to have a lot of chronic mental health problems."
Incarceration	"I have one patient [whose] 16-year-old son was wrongfully incarcerated. She told me her son was on camera somewhere else at the time that the crime was committed. He had a public defender and he's just been locked away for months. He's a kid so of course that [experience] is taking an incredible toll on her mental health."