

Literature Review

Mental Health Disparities

Disparities in health care, including inequalities in mental health care, continue to confound the medical community and policymakers despite efforts to address the problem (Agency for Healthcare Research and Quality, 2014; Safran et al., 2009). Several segments of the U.S. population – including racial and ethnic minorities, sexual minorities, transgender people, people with low incomes, people with disabilities, and people living in certain localities – still experience unequal access to mental health care and treatment, resulting in poorer outcomes. Religious minorities, such as Muslims, may also experience disparities (Padela and Raza, 2015).

By every measure, the disparity in access, treatment, and outcomes is perhaps most salient for racial and ethnic minorities. In a watershed report on mental health, the U.S. Surgeon General said:

Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality (Office of the Surgeon General, 2001, p. 3).

Little has changed since the Surgeon General's report in 2001. For example, Breslau, Kendler, Su, Gaxiola-Aguilar, and Kessler (2005) found that even though non-Hispanic white people were more likely than Hispanic people and non-Hispanic black people* to have a psychiatric disorder in their *lifetime, the latter two groups tended to have more persistent disorders,

* Terms such as "African American," "black," "Latino," "Hispanic," "Native American," "white," and "Asian," are labels used to describe or group people based on shared traits. The different usage of these terms in this literature review reflects the source material. Thus, for example, when this literature review refers to "black people" instead of "African Americans" and vice versa, it is because the authors of the source material used that label.

possibly owing to a lack of access to quality mental health treatment. Similarly, Alegría et al. (2008) observed that Latino, African American, and Asian people were significantly less likely than non-Latino white people to receive access to any mental health treatment for depression. Cook, McGuire, Lock, and Zaslavsky (2010) found that Latinos and African Americans spent far less than whites on mental health care. Sue, Yan Cheng, Saad, and Chu (2012) said that Asian Americans continue to underuse mental health services at rates lower than any other racial and ethnic group, even after controlling for prevalence of mental health disorders. Meanwhile, Meyer, Saw, Cho, and Fanher (2015) found that primary care providers were least likely to ask Asian American patients about mental health and substance use, treat them for such issues, or refer them for specialty care.

It is well-documented that patients' own culture and behaviors contribute to disparities in access, treatment, and outcomes (see, generally, Office of the Surgeon General, 2001). "However, racial and ethnic differences in patient preferences and care-seeking behaviors and attitudes are unlikely to be major sources of health care disparities" (Institute of Medicine, 2003, p. 7). Therefore, the discussion below focuses on how access, treatment, and outcomes are limited by structural inequalities (that is, the way providers and the mental health care systems contribute to disparities).

Unequal Access

In general, access to healthcare services, as measured by insurance coverage, has improved substantially since passage of the Affordable Care Act (ACA) of 2010. From October 2013 – when the law's requirement that people obtain health insurance took effect – to April 2015, the proportion of Americans without health insurance fell from approximately 1-in-5 to nearly 1-in-10 (Levy, 2015). The uninsured rate decreased most among Hispanic and low-income people, who disproportionately comprise racial and ethnic minorities.

The ACA also expanded coverage for mental health and substance use treatment, which had been previously bolstered by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. That law, enacted in 2008, required insurers that offer behavioral health benefits, including substance use treatment, to cover them on a par with medical benefits. The ACA went further by mandating coverage of mental health and substance use treatment as an essential health benefit that many insurers must cover (Goodell, 2014). Implementation of these and related laws have resulted in increased access to mental health and substance use treatment and a decrease in out-of-pocket spending for such services (Sipe et al., 2015).

Nevertheless, racial and ethnic minorities are more likely to be uninsured (Zuvekas and Taliaferro, 2003; McGuire et al., 2006; Cook, Miranda, and McGuire, 2007; Cook et al., 2010). Increasing coverage could go a long way toward reducing disparities. For example, Cook, Doksum, Chen, Carle, and Alegría (2013) found that mental health care access disparities

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between African American and white people decreased as access to HMOs increased. They also found that the presence of community mental health centers helped alleviate disparities in access for African American and Latino people.

Insurance coverage, however, is only one measure of access. Location is also a factor. For example, those who live in rural areas and in majority ethnic communities are more likely to have limited access to mental health services (Cook et al., 2013; Safran et al., 2009).

Access is also a matter of seeing the right health care provider; that is, a mental health specialist such as a psychiatrist, psychologist, or social worker. For example, Cook et al. (2013) found that the density of specialty mental health providers within a county was associated with greater mental health care, especially among African Americans. But, for most people, especially racial and ethnic minorities, a primary care physician is the first professional they encounter in the health care setting (Ferrer, 2007; Meyer, Saw, Cho, & Fancher, 2015). According to Cooper et al. (2003), primary care is the most common place that African American and Hispanic people receive treatment for depression. Thus, it is up to the primary care physician to properly treat or refer patients to a mental health specialist for proper care – yet neither is happening often enough.

Borowsky et al. (2000) found that primary care physicians were less likely to detect mental health problems in African American and Hispanic patients. One reason, according to Alegría et al. (2008), is that physicians are not trained to recognize how mental health disorder symptoms manifest differently across racial and ethnic groups. As an example, they noted Latinos are more likely to seek treatment for the physical manifestations of mental distress rather than the underlying cause. In looking at data over a 10-year period (1995–2005), Stockdale, Lagomasino, Siddique, McGuire, and Miranda (2008) found that primary care physicians were less likely to diagnose African American and Hispanic patients with depression or anxiety and less likely to counsel or refer African American patients to a mental health specialist.

Language is also a barrier to treatment. Sentell, Shumway, and Snowden (2007) suggested that people with limited English proficiency are less likely to receive needed mental health services, regardless of race or ethnicity. Specifically, they found that while approximately half of English-speaking Latino and Asian/Pacific Islander people received needed mental health services, only about 1-in-10 who did not speak English received needed services (Sentell et al., 2007). Similarly, access to mental health services for people who are deaf has been identified as a serious problem (Mathos, Kilbourne, Myers, & Post, 2009).

Healthcare provider bias (discussed further below) can also stymie access. For example, discrimination toward transgender people in health care, including mental health care, is widespread (Bradford, Reisner, Honnold, & Xavier, 2013; Shires & Jaffee, 2015). “The low

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availability of transgender-sensitive providers is a barrier to accessing services for many transgender people, particularly given the gatekeeper role that many mental health providers are perceived to play” (Bradford et al., 2013, p. 1827).

Unequal Treatment

In its seminal report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the Institute of Medicine said that racial and ethnic minorities receive lower-quality health care than others, regardless of insurance status and income (Institute of Medicine, 2003). That means something else is happening within the health care system and clinical setting, where patients and therapists (or physicians) meet, which is contributing to disparities.

For one thing, the mental health care workforce does not reflect the diversity of American society. Of the total number of U.S. psychologists, 83.6 percent are white, 5.3 percent are black, 5.0 percent are Hispanic, and just 4.3 percent are Asian (American Psychological Association, 2015). Social workers, who also provide mental health care, are demographically similar to psychologists (Center for Health Workforce Studies & National Association of Social Workers Center for Workforce Studies, 2006).

According to the President’s New Freedom Commission on Mental Health (2003), which comprised a panel of experts convened by then-President George W. Bush to examine the mental health system, the predominantly white mental health system “has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups” (p. 49). This neglect has resulted in disparate treatment.

As previously mentioned, most people seek or receive treatment for mental health conditions, especially depression and anxiety, from primary care physicians. But the quality of that treatment is often low. According to one study, just 19 percent of people treated by a primary care physician received appropriate care, whereas 90 percent of people treated by a mental health specialist received appropriate care (Young, Klap, Sherbourne, & Wells, 2001). The study’s authors found, however, that, black people were even less likely to receive appropriate care in any setting compared with whites (17 percent for black people versus 34 percent for white people).

Although participatory relationships between doctors and patients are associated with better outcomes, racial and ethnic minorities rate their doctors’ participatory styles the lowest (Xu, Borders, & Arif, 2004). Johnson, Roter, Powe, and Cooper (2004) found that physicians spent less time, were more verbally dominant, and had a less positive affect with African American patients than with white patients.

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Several studies show that non-mental health providers, particularly primary care physicians, are less likely to detect, diagnose, counsel or refer for counseling, and prescribe antidepressant medications for mental health problems, especially among racial and ethnic minority patients (Miranda et al. 2004; Fiscella & Holt, 2007; Reschovsky & O'Malley, 2008; Borowsky et al., 2000; Stockdale et al., 2008; Meyer et al., 2015).

Even among mental health specialists, Larrison and Schoppelrey (2011) found that therapists themselves accounted for 28.7 percent of the variability in outcome disparities among racial and ethnic minority patients in community-based settings, meaning that therapists' own race/ethnicity and multicultural sensitivity play a significant role in patients' treatment outcomes. Hayes, Owen, and Bieschke (2014) observed that some therapists are less effective at reducing racial and ethnic minority clients' psychological symptoms, for reasons including the cultural sensitivity of the therapist. For similar reasons, racial and ethnic minority patients are more likely than white patients to unilaterally end treatment (Owen, Imel, Adelson, & Rodolfa, 2012).

Studies of racial and ethnic disparities in alcoholism treatment have found that minorities are less likely than white people to receive appropriate care and are less satisfied with their care, despite experiencing more detrimental health and social consequences of drinking (Schmidt, Greenfield, & Mulia, 2006).

Clinician bias and stereotyping of ethnic and racial minorities also contribute to disparities in treatment (Institute of Medicine, 2003). It is well-established that racism permeates the U.S. mental health system, and researchers have found that minority clients tend to be misdiagnosed, with more severe psychopathology, more often than white clients. They also tend to be assigned to junior professionals over highly trained professionals, in addition to mistreatment identified elsewhere in this section (Ridley, 2005). For example, in inpatient psychiatric facilities, African American patients are more likely than white patients to receive diagnoses of schizophrenia and drug-related disorders (Delphin-Rittmon et al., 2015). Black patients are also more than twice as likely as white patients to be restrained or put into solitary confinement. Hispanic patients are also more likely than white patients to be restrained or confined, but not nearly as likely as black patients (Donovan, Plant, Peller, Siegel, & Martin, 2003).

A clinician's bias need not be overt or explicit. As John-Henderson (2015) noted, implicit or unconscious bias—that is, bias that clinicians may not be aware of in themselves—"can shape physician behavior in a way that produces differential medical treatment as a function of race, gender, ethnicity, or other individual characteristics" (p. 758).

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Gómez (2015) suggested that minority patients may have less trust in mental health care providers and decreased receptiveness to treatment due to microaggressions, which may be prevalent in mental health care settings, “given the high prevalence of micro-aggressions experienced by black Americans, as well as the racial homogeneity of the mental health care profession” (p. 129). Microaggressions are “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group” (Sue et al., 2007, p. 273).

What is more, the scientific community’s understanding of what distinguishes racial and ethnic groups, as well as its understanding of gender and sexuality, continues to evolve. For example, Sarnquist, Grieb, and Maldonado (2010) argued that the practice of combining Asians and Pacific Islanders into one group for research purposes obscures the differences between the two and may affect the care they receive. Similarly, after exploring the lifetime prevalence of mood and anxiety disorders among people of different sexual orientations, Bostwick, Boyd, Hughes, and McCabe (2010) concluded that grouping together people who report any same-sex sexual behavior, whether it is exclusive same-sex or bisexual behavior, “may inflate risk among some groups, mask risk among others, and obscure the presence of possible protective benefits conferred by exclusive same-sex behavior” (p. 474).

Culturally Sensitive Care

The medical community and policymakers have embraced the belief that health care services should be responsive to the cultural concerns of racial and ethnic minority groups; medical school curricula reflect this belief. Optimal culturally sensitive care, however, is unclear. Certain approaches lack empirical support, while others have mixed reviews.

For example, one approach suggested that matching clients with therapists of the same race or ethnicity would result in better care. However, a meta-analysis of the existing research on the practice found that patients’ outcomes do not depend on the therapist’s race or ethnicity (Cabral & Smith, 2011).

Educational interventions intended to improve the cultural sensitivity of health professionals, such as cultural sensitivity training, have been found to be associated with improved patient outcomes. At the same time, “the current evidence appears to be neither robust nor consistent enough to derive clear guidelines for [culturally sensitive] training to generate the greatest patient impact” (Lie et al., 2011, p. 322). Similarly, a more recent Cochrane review of five randomized controlled trials found “positive, albeit low-quality evidence,” that educational interventions led to improved outcomes among culturally and linguistically diverse patients (Horvat, Horey, Romios, & Kis-Rigo, 2014, p. 27).

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Cabassa and Baumann (2013) noted that multiple meta-analyses of culturally adapted mental health treatments (those that incorporate clients' cultural factors, such as language, cultural values, and gender roles) produced only "small to moderate treatment benefits . . . when compared to an array of controlled/ comparison conditions, including un-adapted [evidence-based treatments], placebo controls, waitlist controls, and/or usual care" (p. 3).

Also, though Flores (2005) found ample evidence in a meta-analysis to support the use of trained professional interpreters or bilingual providers in the treatment of patients with limited English proficiency (LEP), he cautioned that few studies employed a rigorous research design, such as randomized controlled trials, to explore "the most effective and least costly ways to provide interpreter services to LEP patients" (p. 296).

One randomized controlled trial involving the implementation of a quality improvement program found that managed care organizations that implemented the quality improvement program delivered more appropriate care and improved outcomes among Latino and African American patients with depression than those that provided care as usual (Miranda et al., 2003). Nevertheless, "although the intervention in this study provided improved care for the minority patients, minority patients continued to receive lower quality care and incurred poorer health outcomes than did white patients" (Miranda et al, 2003, p. 627).

Some scholars have argued that it is not enough to be culturally sensitive. Metzl and Hansen (2014) said that physicians need to practice "structural competence," if the medical community is to reduce and eliminate health disparities. They said that physicians must be able

to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication 'non-compliance,' trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health (Metzl & Hansen, 2014, p. 5).

Unequal Outcomes

Ultimately, people who have limited access to mental health care and receive poorer quality care have worse outcomes. Outcomes seem to be poorest among black Americans.

Williams et al. (2007) found that, compared with white people, black people diagnosed with major depressive disorder have a poorer prognosis. Similarly, Eack and Newhill (2012) found that, following psychiatric hospitalization, African American people with severe mental illness improved far less than their white counterparts on a variety of critical symptom and functional outcome domains.

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Though the causes are less well-understood, African Americans with severe mental illness are overrepresented among the imprisoned and homeless populations. Researchers who have looked into prison demographics have found that minorities – particularly young, non-white men and especially African Americans – with severe mental illness are more likely to be incarcerated (Fisher et al., 2006; Hawthorne et al., 2012). African Americans with serious mental illness are also more likely than whites and other minorities with mental illness to be homeless (Folsom et al., 2005).

In the United States, black men and women on average live 5.3 and 3.7 fewer years, respectively, than white men and women (Palloni & Yonker, 2014). Chronic conditions take a larger toll on black Americans. Even after controlling for income, black people in the United States are more likely than white people to die from various treatable conditions such as heart disease, cancer, and infection (Richardus & Kunst, 2001). They also have fewer years free of activity limitations caused by chronic conditions (Centers for Disease Control and Prevention, 2013).

Ting et al. (2012) found that black people are now more likely than white people to wind up in hospital emergency departments for suicide attempts and self-inflicted injury. The researchers cited the prevalence of untreated psychiatric disorders among black people as one potential cause.

Additional Resources

The Office of the Surgeon General, mainly through the Office of Minority Health (www.minorityhealth.hhs.gov), leads or supports several initiatives to eliminate health disparities.

The Substance Abuse and Mental Health Services Administration hosts a website devoted to reducing mental health disparities: www.samhsa.gov/health-disparities. The site also contains links to related publications and resources.

The National Institute on Minority Health and Health Disparities, www.nimhd.nih.gov, supports research and public education campaigns, among other things, to improve minority health and eliminate health disparities.

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