Treatment of Mental Illness and Chronic Disease Comorbidity in the Black Community

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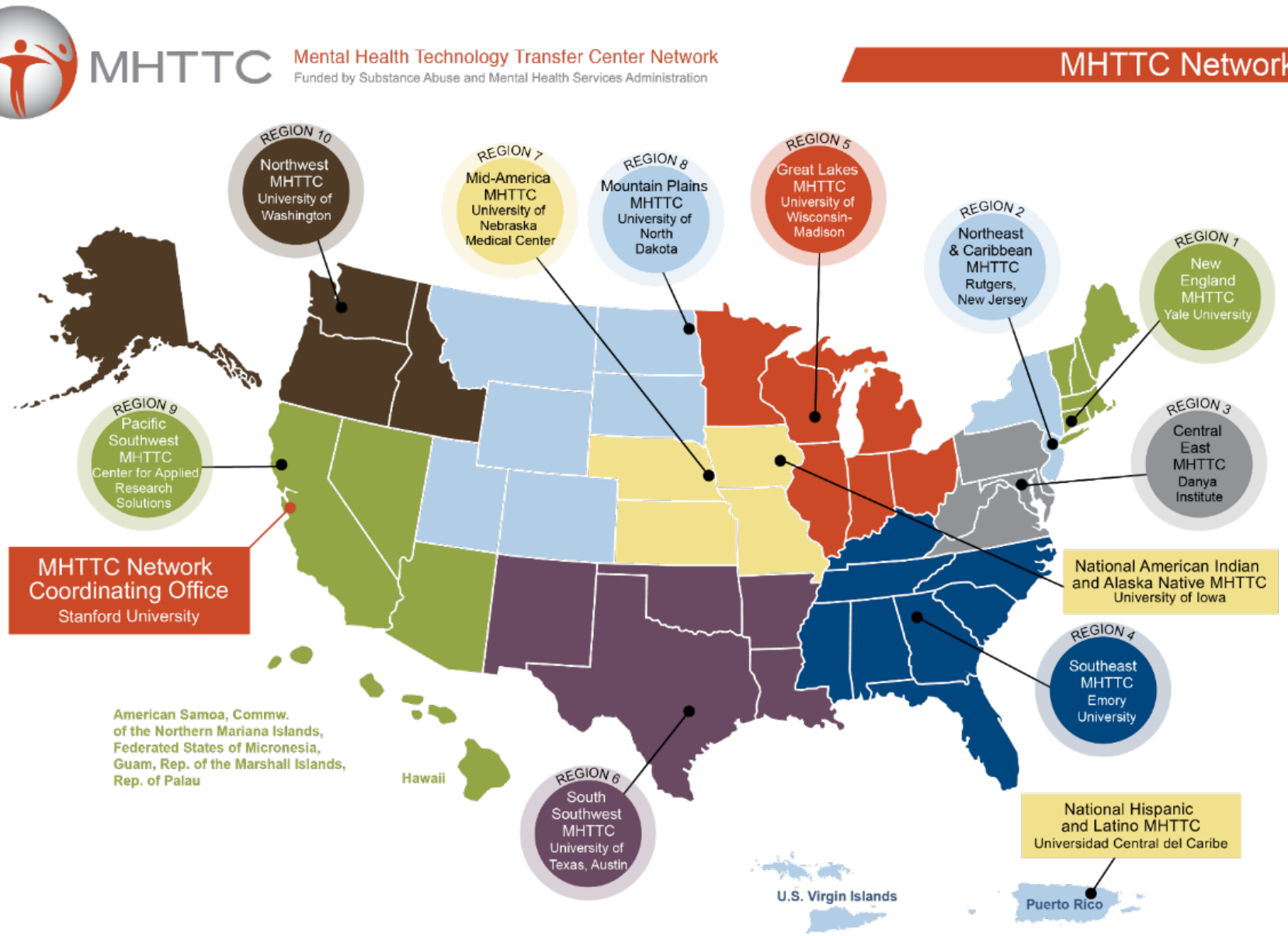
Washtenaw County Community Mental Health

February 17, 2022

Central East (HHS Region 3)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network



MHTTC Purpose

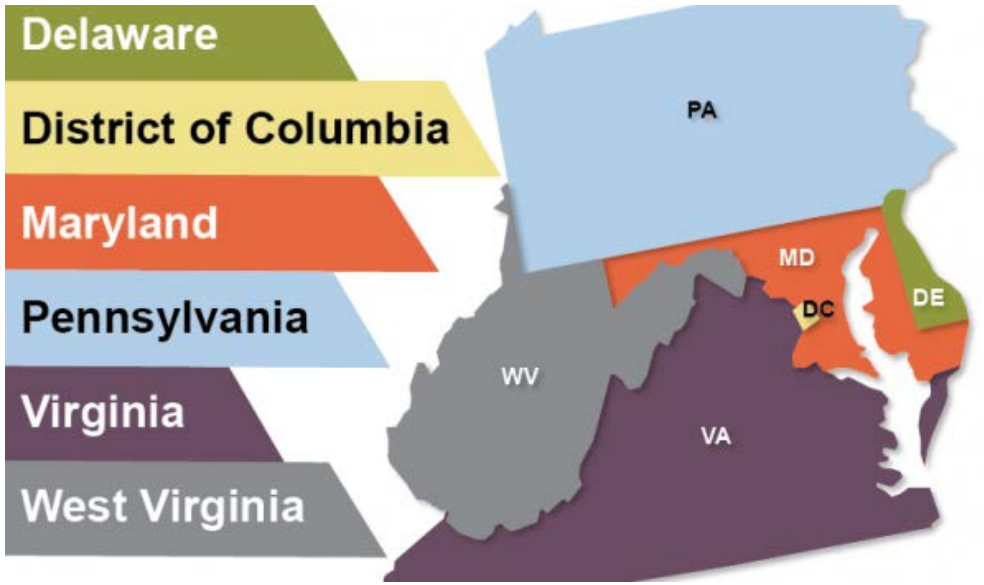
The MHTTC Network vision is to unify science, education and service to transform lives through evidence-based and promising treatment and recovery practices in a recovery-oriented system of care.

Central East MHTTC Goals

Funded by SAMHSA to:

- Accelerate the adoption and implementation of mental health related evidence-based practices
- Heighten the awareness, knowledge, and skills of the behavioral health workforce
- Foster alliances among culturally diverse practitioners, researchers, policy makers, family members, and consumers
- Ensure the availability and delivery of publicly available, free of charge, training and technical assistance

Central East Region 3



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At the time of this presentation, Miriam Delphin-Rittmon served as Assistant Secretary for Mental Health and Substance Use and Administrator of SAMHSA. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by SAMHSA/HHS, or the U.S. Government.

Evaluation Information

As part of receiving funding through SAMHSA to provide this training, the Central East MHTTC is required to submit data related to the quality of this event. At the end of today's presentation, please take a moment to complete a brief survey about today's training.

Treatment of Mental Illness and Chronic Disease Comorbidity in the Black Community

Thursday, February 17, 2022

Presenter: Welton Craig Washington, MD
Adjunct Clinical Professor of Psychiatry
University of Michigan Department of Psychiatry

Moderator: Annelle Primm, MD, MPH
Council of Elders, Black Psychiatrists of America

COVID-19: An Unprecedented Disaster

- Disparate levels of death and economic fallout in Black and other racially marginalized communities
- Mental health consequences include anxiety, depression, substance use, grief and loss, and exacerbation of mental illness
- People with pre-existing diagnoses of chronic disease and mental illness were vulnerable to premature mortality even before the pandemic

Today's Program

- Special thanks to the CE-MHTTC for its support of this session of the Black Psychiatrists of America Health Equity Webinar Series
- Focus is regional on DE, MD, PA, VA, DC, and WV, yet information has national relevance
- Welton Craig Washington, MD, Board Member, Black Psychiatrists of America, is our featured guest

Overview

- What are comorbidities?
- Why do they occur with mental illness?
- Why is this particularly problematic in the African American Community?
- How can we improve outcomes?

What is a Comorbidity?

- Mental disorders include a spectrum of conditions, such as depression, anxiety disorders, schizophrenia and bipolar disorder.
- Comorbidity is defined as the co-occurrence of mental and physical disorders within the same person, regardless of the chronological order in which they occurred or the causal pathway linking them.
- Having a mental disorder is a risk factor for developing a chronic condition, and having a chronic condition is a risk factor for developing a mental disorder.
- When mental and medical conditions co-occur, the combination is associated with elevated symptom burden, functional impairment, decreased length and quality of life, and increased health care costs.

Comorbidities

- Comorbidity between medical and mental conditions is the rule rather than the exception.
- Based on survey data from 2003, 34 million American adults, or 17 percent of the adult population, had comorbid mental and medical conditions within a 12-month period.
- More than 68 percent of adults with a mental disorder reported having at least one general medical disorder, and 29 percent of those with a medical disorder had a comorbid mental health condition.[1,2]

1. Alegria M, Jackson JS, Kessler RC, Takeuchi D. National Comorbidity Survey Replication (NCS-R), 2001–2003. Ann Arbor: Inter-university Consortium for Political and Social Research, 2003.
2. Kessler RC, Berglund P, Chiu WT, Demler O, Heeringa S, Hiripi E, Jin R, Pennell BE, Walters EE, Zaslavsky A, Zheng H. "The US National Comorbidity Survey Replication (NCS-R): Design and Field Procedures." International Journal of Methods in Psychiatric Research, vol. 13, no. 2, 2004.

Comorbidities (cont.)

- More than half of disabled Medicaid enrollees with psychiatric conditions also had claims for diabetes, cardiovascular disease (CVD) or pulmonary disease, substantially higher than rates of these illnesses among persons without psychiatric conditions.
- Approximately 25 percent of American adults meet criteria for at least one diagnosable mental disorder in any given year, and more than half report one or more chronic general medical conditions.[1]

1. Kronick RG, Bella M, Gilmer TP. The Faces of Medicaid III: Refining the Porrait of People with Multiple Chronic Conditions. Center for Health Care Strategies, Inc., 2009

Bidirectionality

- In addition to the high prevalence of these conditions, there is also evidence that having each type of disorder is a risk factor for developing the other.
- The likelihood of having major depression increases with each additional reported comorbid chronic medical disorder.
- The 12-month prevalence of major depression is approximately 5 percent in people without chronic medical conditions, compared with almost 8 percent in people with one condition, 10 percent in people with two conditions, and 12 percent in people with three or more medical conditions.[1]

1. Egede LE. “Major Depression in Individuals with Chronic Medical Disorders: Prevalence, Correlates and Association with Health Resource Utilization, Lost Productivity and Functional Disability.” General Hospital Psychiatry, vol. 29, no. 5, 2007

Why Do Comorbidities Occur?

- The pathways leading to comorbidity of mental and medical disorders are complex and bidirectional.
- Medical conditions that are accompanied by a high symptom burden, such as migraine headaches or back pain, can lead to depression.[1]
- Major depression is a risk factor for developing medical conditions, such as cardiovascular disease, that are characterized by pain or inflammation.[2]

1. Patten SB. "Long-Term Medical Conditions and Major Depression in a Canadian Population Study at Waves 1 and 2." Journal of Affective Disorders, vol. 63, no. 1–3, 2001.
2. Patten SB, Williams JVA, Lavorato DH, Modgill G, Jette N, Eliasziw M. "Major Depression as a Risk Factor for Chronic Disease Incidence: Longitudinal Analyses in a General Population Cohort." General Hospital Psychiatry, vol. 30, no. 5, 2008

Childhood Experiences

- Exposure to adverse childhood experiences such as trauma, abuse, and chronic stress are all associated with both mental and medical disorders, and responsible for much of the high rates of comorbidity, burden of illness, and premature death associated with chronic illness.
- People who experience more adverse exposures during childhood are more likely to report depression, suicide attempts, and chronic medical conditions.[1,2,3]

1. Black PH. “The Inflammatory Consequences of Psychologic Stress: Relationship to Insulin Resistance, Obesity, Atherosclerosis and Diabetes Mellitus, Type II.” Medical Hypotheses, vol. 67, no. 4, 2006.
2. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study.” American Journal of Preventive Medicine, vol. 14, no. 4, 1998
3. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study.” American Journal of Preventive Medicine, vol. 14, no. 4, 1998

Chronic Stressors

- Chronic stressors, such as lack of money for basic needs, care-giving responsibilities, conflict in relationships, or dealing with long-term medical conditions, are particularly strong predictors of depression.[1]
- Traumatic events throughout the lifespan, including intimate partner violence, can lead to PTSD.

1. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study.” American Journal of Preventive Medicine, vol. 14, no. 4, 1998

Inflammation

- One mechanism that may underlie the relationship between stress and health conditions is that exposure linked to a weakening of the immune system and an increase in the inflammatory response, which are risk factors for medical disorders.[1,2,3,4]
- Mental disorders, such as depression, are linked to altered immune function including increased production of cytokines, small signaling proteins that are part of the body's inflammatory response.[5,6]
- The inflammatory response is critical for dealing with injury or infection but becomes problematic when sustained as a result of chronic stress.

1. Black PH. "The Inflammatory Consequences of Psychologic Stress: Relationship to Insulin Resistance, Obesity, Atherosclerosis and Diabetes Mellitus, Type II." Medical Hypotheses, vol. 67, no. 4, 2006.
2. Black PH, Garbutt LD. "Stress, Inflammation and Cardiovascular Disease." Journal of Psychosomatic Research, vol. 52, no. 1, 2002
3. Khansari DN, Murgo AJ, Faith RE. "Effects of Stress on the Immune System." Immunology Today, vol. 11, no. 5, 1990
4. Lin, W. J., F. Shao, and C. Washington. "The effects of emotional stress on the primary humoral immunity in rats.", Acta Psychologica Sinica, 2000.
5. Mental disorders, such as depression, are linked to altered immune function including increased production of cytokines, small signaling proteins that are part of the body's inflammatory response
6. Kiecolt-Glaser JK, Glaser R. "Depression and Immune Function—Central Pathways to Morbidity and Mortality." Journal of Psychosomatic Research, vol. 53, no. 4, 2002

Socioeconomic Factors

- Socioeconomic factors, such as low income and poor educational attainment, are associated with mental disorders and medical conditions.
- People of low socioeconomic status are 1.8 times more likely to report being depressed than people who have a higher status.[1]
- SES may both contribute to the onset of mental disorders and be a consequence of downward “drift” resulting from a mental disorder.[2]
- SES can also influence prevalence, morbidity and mortality of medical conditions, such as coronary heart disease and diabetes.[3,4]

1. Lorant V, Deliege D, Eaton W, Robert A, Philippot P, Ansseau M. “Socioeconomic Inequalities in Depression: A Meta-Analysis.” American Journal of Epidemiology, vol. 157, no. 2, 2003
2. 2. Eaton WW, Muntaner C. “Socioeconomic Stratification and Mental Disorder.” In A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems, Horowitz AV and Scheid TL (eds). Cambridge: Cambridge University Press, 1999. pp. 259–283.
3. Butler M, Kane R, McAlpine D, Kathol RG, Fu SS, Hagedorn H, Wilt TJ. Integration of Mental Health/ Substance Abuse and Primary Care. Minneapolis: Minnesota Evidence-Based Practice Center, 2009
4. Drewnowski A. “Obesity, Diets, and Social Inequalities.” Nutrition Reviews, vol. 67, no. 5, 2009.

Poor Social Support

- People with low social support consistently report higher levels of depressive symptoms.[1,2 3]
- Poor social support leads to worse outcomes in schizophrenia and bipolar disorder.[4, 5]
- Poor social support is negatively linked to medical conditions.
- Low social support raises the risk of developing coronary heart disease 1.5 to 2 times.[6]

1. Reisinger EL, DiIorio C. "Individual, Seizure-Related, and Psychosocial Predictors of Depressive Symptoms among People with Epilepsy over Six Months." Epilepsy & Behavior, vol. 15, no. 2, 2009
2. Turner RJ. "Social Support and Coping." In A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems, Horowitz AV and Scheid TL (eds). Cambridge: Cambridge University Press, 1999, pp. 198–210
3. van den Akker M, Buntinx F, Metsemakers JFM, Roos S, Knottnerus JA. "Multimorbidity in General Practice: Prevalence, Incidence, and Determinants of Co-Occurring Chronic and Recurrent Diseases." Journal of Clinical Epidemiology, vol. 51, no. 5, 1998.
4. Buchanan J. "Social Support and Schizophrenia: A Review of the Literature." Archives of Psychiatric Nursing, vol. 9, no. 2, 1995.
5. Johnson L, Lundstrom O, Aberg-Wistedt A, Mathe AA. "Social Support in Bipolar Disorder: Its Relevance to Remission and Relapse." Bipolar Disorders, vol. 5, no. 2, 2003.
6. Lett HS, Blumenthal JA, Babyak MA, Strauman TJ, Robins C, Sherwood A. "Social Support and Coronary Heart Disease: Epidemiologic Evidence and Implications for Treatment." Psychosomatic Medicine, vol. 67, no. 6, 2005.

Adverse Environmental Conditions

- Low socioeconomic status reduces available resources, such as social support, and increases the chances of exposure to adverse environmental conditions.[1]

1. Phelan JC, Link BG, Diez-Roux A, Kawachi I, Levin B. "'Fundamental Causes' of Social Inequalities in Mortality: A Test of the Theory." Journal of Health and Social Behavior, vol. 45, no. 3, 2004

Disadvantaged Communities

- Environmental and neighborhood conditions associated with disadvantage, such as low-quality schools and housing, limited employment prospects, and problems in access to health care services, public transportation or other resources, have a profound impact on individuals' well-being and mental health.
- People in disadvantaged communities often have limited access to healthy food options and may not be able to afford healthier choices, which contributes to high rates of obesity and diabetes.

Modifiable Health Risk Behaviors

- Tobacco use, excessive alcohol and illicit drug consumption, lack of physical activity, and poor nutrition are responsible for much of the increase in comorbidity.[1]
- Persons with mental disorders are at elevated risk for each of these types of behaviors, which raises their risk of developing chronic illnesses and having poor outcomes.

1. Centers for Disease Control and Prevention. Chronic Diseases and Health Promotion. 2010; www.cdc.gov/ chronicdisease/overview/. Accessed August 9, 2010.

Adverse Health Behaviors

- People who experience chronic stressors or negative events in childhood may also be more likely to engage in adverse health behaviors that are linked with medical conditions.[1]
- People of low socioeconomic status are more likely to engage in adverse health behaviors, such as eating a poor diet, smoking and not exercising, which in turn contribute to the development of chronic medical conditions.[2,3]

1. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine, vol. 14, no. 4, 1998
2. Brezinka V, Kittel F. "Psychosocial Factors of Coronary Heart Disease in Women: A Review." Social Science & Medicine, vol. 42, no. 10, 1996.
3. Kronick RG, Bella M, Gilmer TP, Somers S. Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions. Center for Health Care Strategies, Inc., 2007.

Alcohol and Nicotine

- People with a diagnosis of a mental disorder in the past month are thought to smoke approximately 44 percent of all cigarettes in the United States and are two to three times as likely to smoke compared with those without a mental disorder.[1,2]
- Compared with people without severe mental illness, people treated for schizophrenia and bipolar disorder are 12 and 20 times more likely to be treated for alcohol abuse, and 35 and 42 times more likely to be dependent on illegal drugs.[3, 4]

1. Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, McCormick D, Bor DH. “Smoking and Mental Illness: A Population-Based Prevalence Study.” Journal of the American Medical Association, vol. 284, no. 20, 2000.
2. Glassman AH, Helzer JE, Covey LS, Cottler LB, Stetner F, Tipp JE, Johnson J. “Smoking, Smoking Cessation, and Major Depression.” Journal of the American Medical Association, vol. 264, no. 12, 1990.
3. Carney CP, Jones L, Woolson RF. “Medical Comorbidity in Women and Men with Schizophrenia: A Population Based Controlled Study.” Journal of General Internal Medicine, vol. 21, no. 11, 2006.
4. Carney CP, Jones LE. “Medical Comorbidity in Women and Men with Bipolar Disorders: A Population-Based Controlled Study.” Psychosomatic Medicine, vol. 68, no. 5, 2006

Sedentary Lifestyle

- People with mental conditions are more likely to have sedentary lifestyles and poor diets.
- People with severe mental illness, including schizophrenia, bipolar disorder, or major depression, report less physical activity and tend to eat foods that are high in fat and calories while avoiding fruits and vegetables.[1,2]

1. Compton MT, Daumit GL, Druss BG. “Cigarette Smoking and Overweight/Obesity among Individuals with Serious Mental Illnesses: A Preventive Perspective.” Harvard Review of Psychiatry, vol. 14, no. 4, 2006.
2. Daumit GL, Goldberg RW, Anthony C, Dickerson F, Brown CH, Kreyenbuhl J, Wohlheiter K, Dixon LB. “Physical Activity Patterns in Adults with Severe Mental Illness.” Journal of Nervous and Mental Disease, vol. 193, no. 10, 2005.

Impact of Treatment

- Many of the most common treatments for diseases may actually worsen the comorbid condition.
- Many psychotropic medications can cause weight gain, a risk factor for type 2 diabetes.
- Many treatments for common medical conditions can have psychological side effects that may exacerbate or complicate underlying psychiatric conditions.

Decreased Motivation

- Many chronic medical conditions require patients to maintain a self-care regimen in order to manage symptoms and prevent further disease progression, which may be hampered by comorbid mental conditions.
- Depression may decrease the motivation and energy needed to perform self-management behaviors and may also adversely impact interpersonal relationships, including collaboration with physicians.[1]
- People with severe mental illness often exhibit poor adherence to both psychiatric medications and medications for medical conditions.[2]

1. Katon WJ. “Clinical and Health Services Relationships between Major Depression, Depressive Symptoms, and General Medical Illness.” Biological Psychiatry, vol. 54, no. 3, 2003
2. Piette JD, Heisler M, Ganoczy D, McCarthy JF, Valenstein M. “Differential Medication Adherence among Patients with Schizophrenia and Comorbid Diabetes and Hypertension.” Psychiatric Services, vol. 58, no. 2, 2007.

Increased Burden

- When mental and medical conditions co-occur, the combination is associated with elevated symptom burden, functional impairment, decreased length and quality of life, and increased costs.[1,2,3,4]
- Mental disorders are associated with a twofold to fourfold elevated risk of premature mortality.[5,6,7]

1. Dickerson F, Brown CH, Fang L, Goldberg RW, Kreyenbuhl J, Wohlheiter K, Dixon L. "Quality of Life in Individuals with Serious Mental Illness and Type 2 Diabetes." Psychosomatics, vol. 49, no. 2, 2008.
2. Egede LE. "Major Depression in Individuals with Chronic Medical Disorders: Prevalence, Correlates and Association with Health Resource Utilization, Lost Productivity and Functional Disability." General Hospital Psychiatry, vol. 29, no. 5, 2007.
3. Katon WJ. "Clinical and Health Services Relationships between Major Depression, Depressive Symptoms, and General Medical Illness." Biological Psychiatry, vol. 54, no. 3, 2003.
4. Stein MB, Cox BJ, Afifi TO, Belik SL, Sareen J. "Does Co-Morbid Depressive Illness Magnify the Impact of Chronic Physical Illness? A Population-Based Perspective." Psychological Medicine, vol. 36, no. 5, 2006.
5. Colton CW, Manderscheid RW. "Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death among Public Mental Health Clients in Eight States." Preventing Chronic Disease, vol. 3, no. 2, 2006.
6. Eaton WW, Martins SS, Nestadt G, Bienvenu OJ, Clarke D, Alexandre P. "The Burden of Mental Disorders." Epidemiologic Reviews, vol. 30, no. 1, 2008
7. Felker B, Yazel JJ, Short D. "Mortality and Medical Comorbidity among Psychiatric Patients: A Review." Psychiatric Services, vol. 47, no. 12, 1996.

Quality of Care

- People with mental and substance use disorders are less likely than individuals in the general population to receive preventive services such as immunizations, cancer screenings, and smoking cessation counseling, and receive worse quality of care.[1,2]
- In primary care, common psychiatric comorbidities, such as depression, often go undetected and undiagnosed.[3,4]

1. Druss BG, Rosenheck RA, Desai MM, Perlin JB. "Quality of Preventive Medical Care for Patients with Mental Disorders." Medical Care, vol. 40, no. 2, 2002.
2. Mitchell AJ, Malone D, Doebbeling CC. "Quality of Medical Care for People with and without Comorbid Mental Illness and Substance Misuse: Systematic Review of Comparative Studies." British Journal of Psychiatry, vol. 194, no. 6, 2009.
3. Coulehan JL, Schulberg HC, Block MR, Janosky JE, Arena VC. "Medical Comorbidity of Major Depressive Disorder in a Primary Medical Practice." Archives of Internal Medicine, vol. 150, no. 11, 1990.
4. Higgins ES. "A Review of Unrecognized Mental Illness in Primary Care. Prevalence, Natural History, and Efforts to Change the Course." Archives of Family Medicine, vol. 3, no. 10, 1994.

Under-recognition and Undertreatment of Medical Problems for Persons with Mental Conditions

- Symptoms of mental illness such as lack of motivation, fearfulness and distrust may reduce their ability to initiate and follow through with medical treatment.
- African Americans, in particular, have significant distrust of the health care system.
- Primary care physicians may feel uncomfortable treating persons with serious mental illness. Psychiatrists and other mental health care providers may feel uncomfortable providing general medical care.
- Fragmentation and separation between the medical and mental health care systems result in individuals with comorbid conditions receiving care from multiple uncoordinated locations.[1]

1. Druss BG, von Esenwein SA. "Improving General Medical Care for Persons with Mental and Addictive Disorders: Systematic Review." General Hospital Psychiatry, vol. 28, no. 2, 2006.

Increased Costs

- The presence of comorbid depression or anxiety significantly increased medical and mental health care expenditures, with over 80 percent of the increase occurring in medical expenditures.[1]
- General medical costs were 40 percent higher for people treated with bipolar disorder than without it.[2]

1. Melek S, Norris D. Chronic Conditions and Comorbid Psychological Disorders. Seattle: Milliman, 2008
2. Simon GE, Unutzer J. “Health Care Utilization and Costs among Patients Treated for Bipolar Disorder in an Insured Population.” Psychiatric Services, vol. 50, no. 10, 1999.

The Impact of Comorbidities in the African American Community

Social Determinants

- One of the most important social determinants of health is race.
- Results from racial differences in discrimination, stress, neighborhoods, housing, access to quality health care, and other factors.[1,2,3]
- Race is often associated with socioeconomic status (SES), SES is unable to completely explain racial differences in health and disease.[4,5]

1. D.R. Williams, S.A. Mohammed, J. Leavell, C. Collins “Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities” Ann N Y Acad Sci, 1186 (2010)
2. D.R. Williams, R. Wyatt “Racial bias in health care and health: challenges and opportunities” JAMA, 314 (6) (2015)
3. D.R. Williams, J. Leavell “The social context of cardiovascular disease: challenges and opportunities for the Jackson Heart Study” Ethn Dis, 22 (3 suppl 1) (2012)
4. W.C. Cockerham “Social Causes of Health and Disease” (2nd ed.), Polity, Cambridge, UK (2013)
5. D. Conley, K.W. Strully, N.G. Bennett “The Starting Gate: Birth Weight and Life Chances” University of California Press, Berkeley (2003)

Cardiovascular Disease in African Americans

- CVD mortality rates are historically higher for blacks than whites.
- Centers for Disease Control and Prevention data showing non-Hispanic death rates per 100,000 of 289.6 for blacks and 222.0 for whites in 2014.[1]

1. CDC, National Center for Health Statistics. Multiple causes of Death 1999-2014. CDC WONDER Website. Published 2015

Disparate Care

- African Americans receive disparate care for a number of conditions, including cardiac care.[1,2]
- Most caregivers are oblivious to such disparate care differences.[3]

Jha AK, Fisher ES, Li Z, Orav EJ, Epstein AM. Racial trends in the use of major procedures among the elderly. N Engl J Med. 2005.
Lurie N, Fremont A, Jain A, et al. Racial and ethnic disparities in care: the perspectives of cardiologists. Circulation. 2005.
Kaiser Family Foundation. Racial and Ethnic Difference in Cardiac Care

Barriers to Care

- Only one-in-three African Americans who need mental health care receives it.[1]
- Compared with the general population, African Americans are less likely to be offered either evidence-based medication therapy or psychotherapy.[2]
- Physician-patient communication differs for African Americans and Whites. One study found that physicians were 23% more verbally dominant, and engaged in 33% less patient-centered communication with African American patients than with White patients.[3]

1. Dalencour M, et al. “The Role of Faith-Based Organizations in the Depression Care of African Americans and Hispanics in Los Angeles.” Psychiatric Services. 2017. 68(4):368-374
2. Wang PS, Berglund P, Kessler RC. “Recent care of common mental disorders in the Unites States: Prevalence and conformance with evidence-based recommendations.” J Gen Intern Med. 2000. 15(5), 284-292
3. Johnson R, et al. “Patient race/ethnicity and quality of patient-physician communication during medical visits.” Am J Public Health. 2004. 94(12), 2084-90.

Barriers to Care (cont.)

- Stigma associated with mental illness.
- Distrust of the health care system.
- Lack of providers from diverse racial/ethnic backgrounds.
- Lack of culturally competent providers.
- Lack of insurance, underinsurance.

Perceived Racial Discrimination

- Perceived racial discrimination is a prominent health risk factor associated with a range of adverse outcomes, from cardiovascular disease to low birth weight, smoking, and poor self-reported health.[1, 2, 3]
- Patients who report perceived discrimination tend to forego preventive services, postpone medical tests and treatment, and underutilize health services in general.[4, 5, 6, 7]

1. J.Q. Purnell, L.J. Peppone, K. Alcaraz, *et al. "*Perceived discrimination, psychological distress, and current smoking status: results from the Behavioral Risk Factor Surveillance System Reactions to Race module", 2004–2008 Am J Public Health, 102 (5) (2012)
2. D.R. Williams "Race, socioeconomic status, and health. The added effects of racism and discrimination" Ann N Y Acad Sci, 896 (1999)
3. G.C. Gee, A. Ro, S. Shariff-Marco, D. Chae "Racial discrimination and health among Asian Americans: evidence, assessment, and directions for future research" Epidemiol Rev, 31 (1) (2009)
4. K.L. Gonzales, A.K. Harding, W.E. Lambert, R. Fu, W.G. Henderson "Perceived experiences of discrimination in health care: a barrier for cancer screening among American Indian women with type 2 diabetes" Womens Health Issues, 23 (1) (2013)
5. E.A. Jacobs, P.J. Rathouz, K. Karavolos, *et al. "*Perceived discrimination is associated with reduced breast and cervical cancer screening: the Study of Women's Health Across the Nation (SWAN)" J Womens Health, 23 (2) (2014)
6. A.N. Trivedi, J.Z. Ayanian "Perceived discrimination and use of preventive health services" J Gen Intern Med, 21 (6) (2006)
7. D.J. Burgess, Y.M. Ding, M. Hargreaves, M. van Ryn, S. Phelan "The association between perceived discrimination and underutilization of needed medical and mental health care in a multi-ethnic community sample" J Health Care Poor Underserved, 19 (3) (2008)

Solutions

- Models that integrate care to treat people with mental health and medical comorbidities have proven effective.
- The most effective and cost-effective treatment for persons with comorbid mental and medical conditions involves a collaborative care approach that uses a multidisciplinary team to screen and track mental conditions in a primary care setting.

Collaborative Care

- Care managers provide patient education, aide patients with treatment decision making, monitor symptoms, provide follow-up care, and communicate with the team.[1, 2]
- Stepped care involves tracking and monitoring medical and mental outcomes and adjusting services or moving to a higher level of intensity as needed.[3]
- Highly cost-effective from a societal perspective.[4,5]

1. Bower P, Gilbody S, Richards D, Fletcher J, Sutton A. "Collaborative Care for Depression in Primary Care— Making Sense of a Complex Intervention: Systematic Review and Meta-Regression." British Journal of Psychiatry, vol. 189, 2006.
2. Bruce ML, Ten Have TR, Reynolds CF, Katz II, Schulberg HC, Mulsant BH, Brown GK, McAvay GJ, Pearson JL, Alexopoulos GS. "Reducing Suicidal Ideation and Depressive Symptoms in Depressed Older Primary Care Patients: A Randomized Controlled Trial." Journal of the American Medical Association, vol. 291, no. 9, 2004.
3. Mauer BJ, Druss BG. Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface. Albuquerque: American College of Mental Health Administration, 2007.
4. Katon WJ, Schoenbaum M, Fan MY, Callahan CM, Williams J, Jr., Hunkeler E, Harpole L, Zhou XH, Langston C, Unutzer J. "Cost-Effectiveness of Improving Primary Care Treatment of Late-Life Depression." Archives of General Psychiatry, vol. 62, no. 12, 2005.
5. Schoenbaum M, Unutzer J, Sherbourne C, Duan N, Rubenstein LV, Miranda J, Meredith LS, Carney MF, Wells K. "Cost-Effectiveness of Practice-Initiated Quality Improvement for Depression: Results of a Randomized Controlled Trial." Journal of the American Medical Association, vol. 286, no. 11, 2001.

Integrated Models

- In fully integrated medical, mental health, and substance use (MH/SU) health models, staff within a single organization provide primary and MH/SU health care.
- A partnership model is one in which primary care staff are embedded in a community MH/SU organization and/or MH/SU staff are embedded in a primary care setting.
- A facilitated referral model is one in which primary care staff are not physically present in the MH/SU organization, but the MH/SU organization conducts physical health screenings, coordinates referrals to primary care, and shares information with primary care.

Improved Communication

- Lack of communication between the mental health and medical systems has been an important factor underlying poor quality of care for persons with comorbid conditions.[1]
- Health Information Exchanges (HIEs) have been formed to develop electronic networks containing data elements essential to care coordination that can be accessed by diverse participating health care organizations in a defined geographic region.

1. Institute of Medicine (U.S.). Committee on Crossing the Quality Chasm. Adaptation to Mental Health and Addictive Disorders. Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington: 2006.

Culturally Competent Care

- Many African Americans today, regardless of socioeconomic status, still carry lingering mistrust as the result of this legacy of mistreatment and lack of informed consent.
- Tuskegee experiment.
- Disparity in schizophrenia diagnosis.[1]
- One recent study found that 40% of first- and second-year medical students endorsed the belief that “black people’s skin is thicker than white peoples”.[2]

1. Lawson W. Arch Gen Psychiatry. 2012;69:593-600
2. Hoffman K, Trawalter S, Racial bias in pain assessment, Proceedings of the National Academy of Sciences Apr 2016.

What Can We Do?

- Cultural sensitivity is imperative.
- Cultural formulation interview.
- What concerns the patient most?
- Why they think this is happening?
- What matters most to them?
- How would they like to be helped?

Overcoming Mental Health Stigma

- Shift media narratives.
- Tell stories that prove people can lead rich lives.
- Increase access to mental health care.
- Raise awareness around mental health in young people.

Summary

- Co-occurring mental and physical disorders contribute significantly to morbidity and mortality and carry a high societal cost.
- The causes of comorbidity are complex and bidirectional.
- The impact of these comorbidities in the African American community is particularly problematic given the disparate impact of chronic medical conditions and poorer care received.
- Collaborative care is necessary to treat comorbid conditions.
- Culturally competent care is important.

Questions

Appreciation

Contact Us

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