



# Reducing Racial and Ethnic Disparities in Mental Health Care through Policy and Practice

Pamela Y. Collins, MD, MPH

Professor of Psychiatry & Behavioral Sciences and Global Health

University of Washington



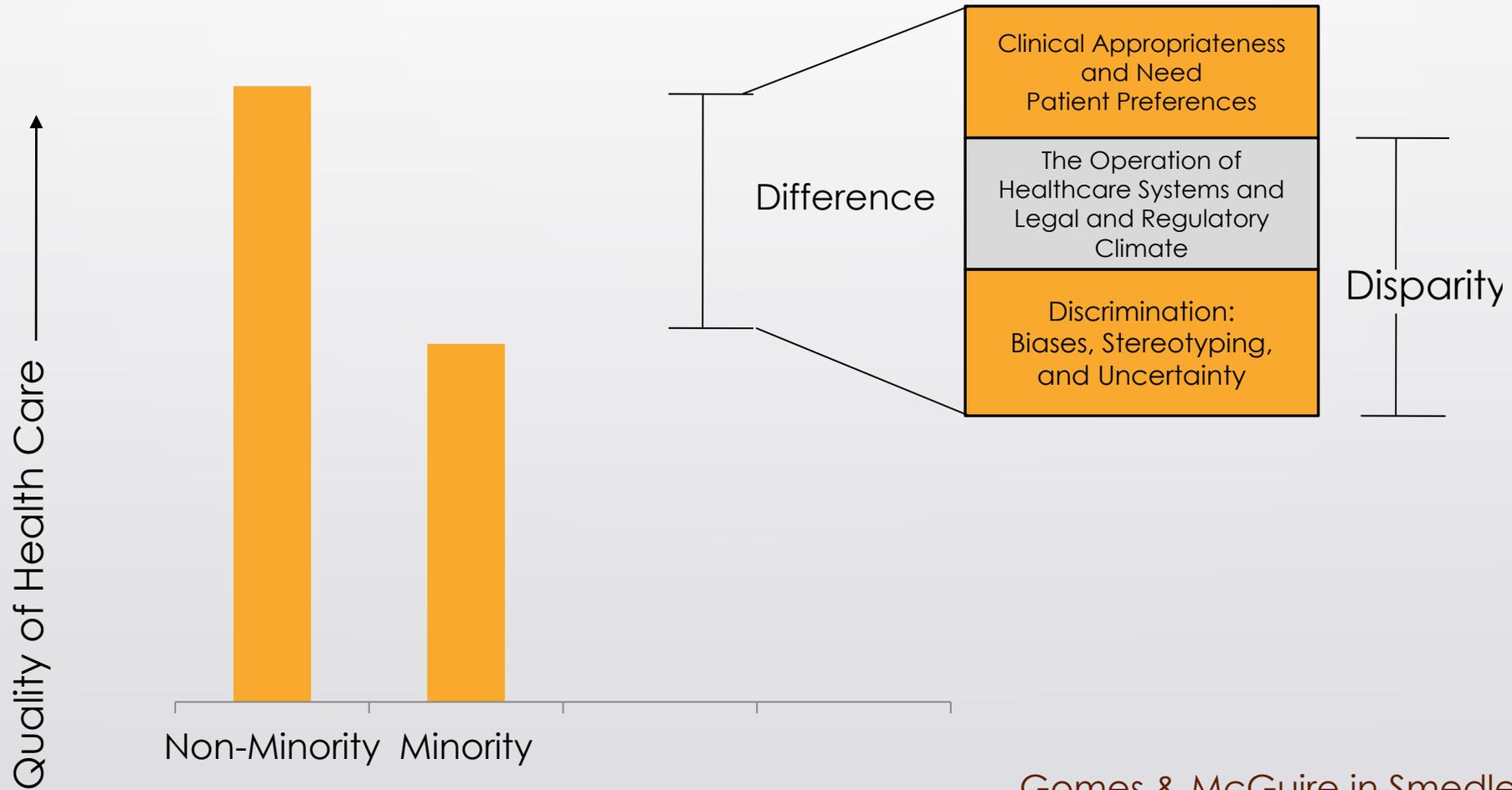
# Defining Disparities

## Definitions

Health status disparity: Any inequality in health due to social factors or allocation of resources that is unjust [Miranda et al 2008 AJP](#)

Health care disparities: Any difference in health care quality not due to differences in health care needs or preferences [Smedley et al 2003 IOM](#)

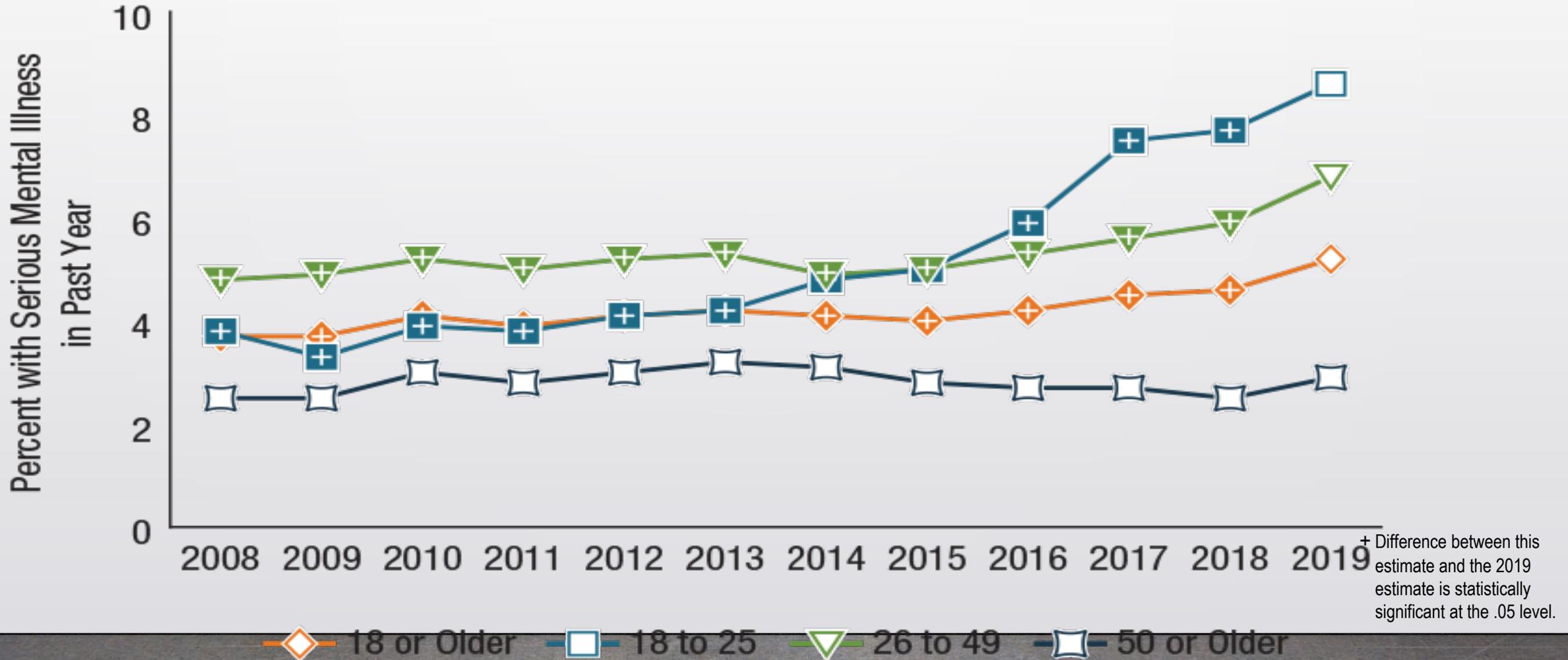
# Difference, Disparities and Discrimination



Gomes & McGuire in Smedley et al 2003 IOM

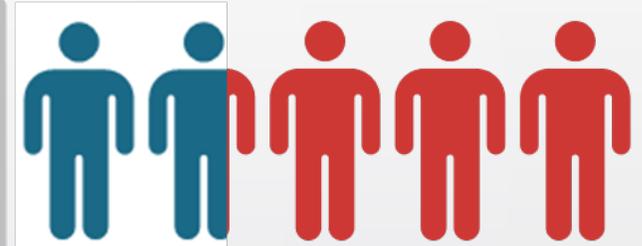
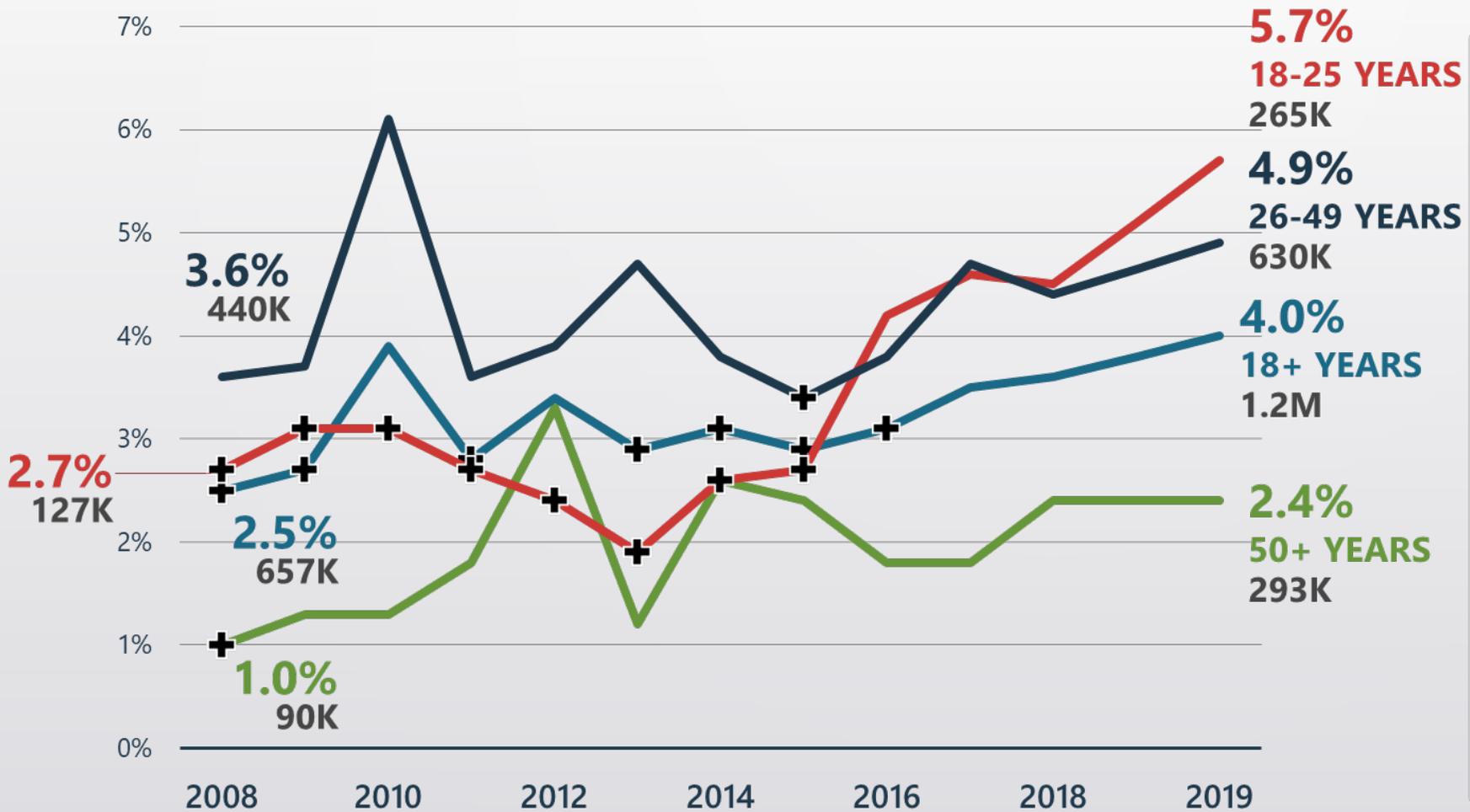
# PM152

## Serious Mental Illness in the Past Year among Adults Aged 18 or Older: 2008-2019 (NSDUH 2019)



# Serious Mental Illness (SMI) among African Americans

PAST YEAR, 2008-2019 NSDUH, African American 18+

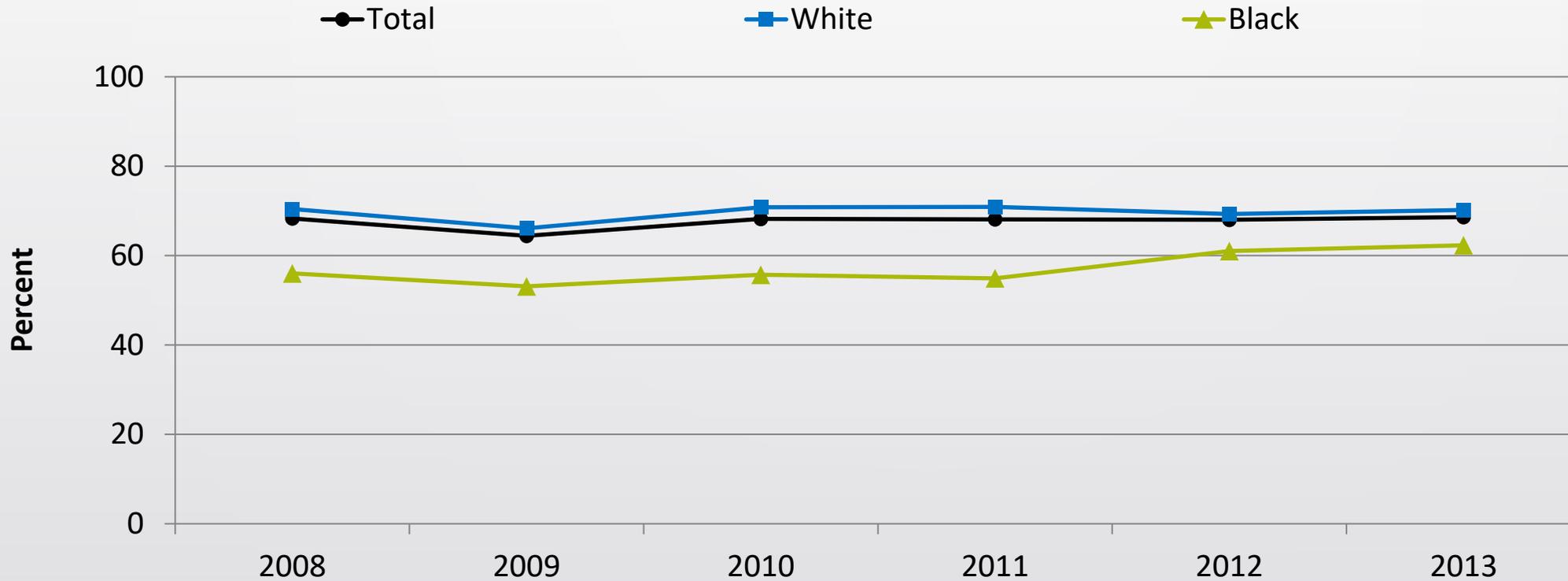


**34.6%**  
**91,000 AFRICAN AMERICAN YOUNG ADULTS WITH SMI RECEIVED TREATMENT IN 2019**  
**65.4% got NO treatment**

**58.1%**  
**366,000 AFRICAN AMERICAN ADULTS AGED 26-49 WITH SMI RECEIVED TREATMENT IN 2019**  
**41.9% got NO treatment**

+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Adults with a major depressive episode in the past year who received treatment for depression in the past year, by race, 2008-2013

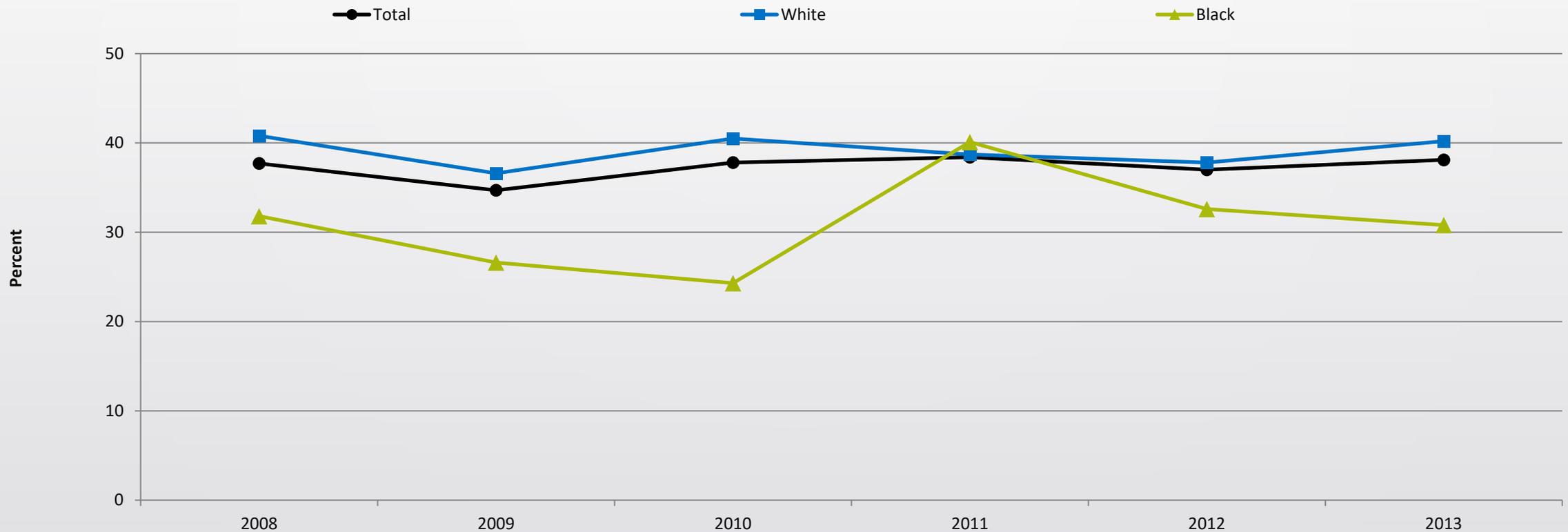


**Source:** Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2008-2013.

**Denominator:** Adults age 18 and over with a major depressive episode in the past year.

**Note:** Major depressive episode is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms of depression described in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Treatment for depression is defined as seeing or talking to a medical doctor or other professional or using prescription medication in the past year for depression.

Adolescents with a major depressive episode in the past year who received treatment for depression in the past year, by race, 2008-2013



**Source:** Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2008-2013.

**Denominator:** Adolescents ages 12-17 with a major depressive episode in the past year.

**Note:** Major depressive episode is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms of depression described in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Treatment for depression is defined as seeing or talking to a medical doctor or other professional or using prescription medication in the past year for depression.

# Discrimination and health disparities

Williams et al, 2019

- Socioeconomic status (SES) is a strong predictor of health disparities

Racial disparities persist at every level of SES

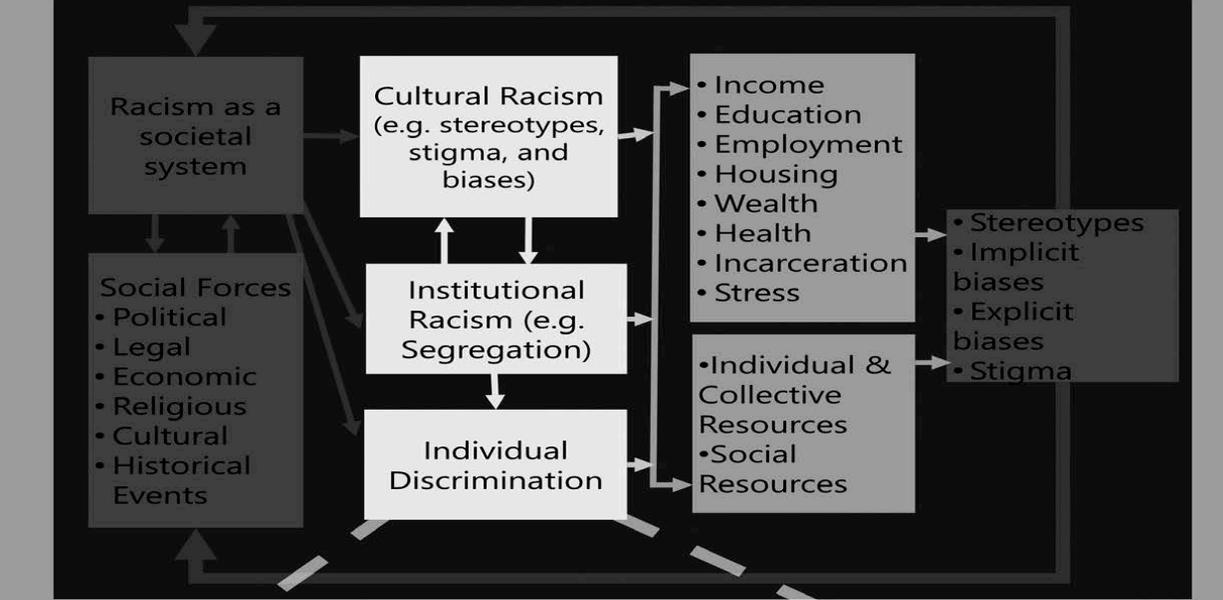
- Racism and health inequities – 3 pathways:

*Cultural racism*

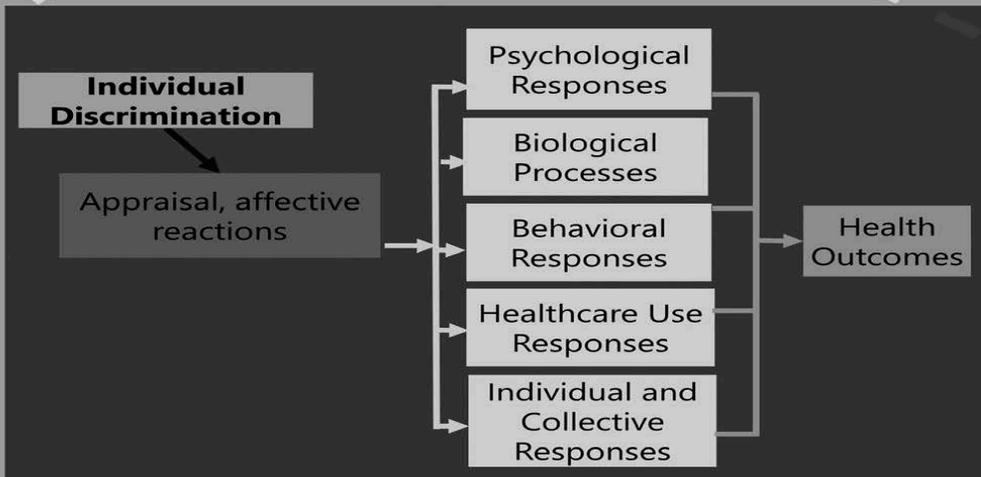
*Institutional or structural racism*

*Individual level discrimination*

Figure 1. The House that Racism Built



...the multiple pathways individual discrimination affects health.



## Discrimination

-poorer mental health

-depression, anxiety, psychological stress

-negative emotions

-declines in trusting

-declines in conscientiousness

## Protective Factors

-religious beliefs and behavior

- emotional support

# Chester Pierce, MD – African American Harvard psychiatrist and stress researcher – coined the term “microaggression”

Daniel Solórzano, *University of California–Los Angeles*; Miguel Ceja, *University of California–Davis*; and Tara Yosso, *University of California–Santa Barbara*

*Microaggressions are subtle insults (verbal, nonverbal, and/or visual) directed toward people of color, often automatically or unconsciously. Using critical race theory as a framework, the study described in this article provides an examination of racial microaggressions and how they influence the collegiate racial climate. Using focus group interview data from African American students at three universities, it reveals that racial microaggressions exist in both academic and social spaces in the collegiate environment. The study shows how African American students experience and respond to racial microaggressions. It also demonstrates how racial microaggressions have a negative impact on the campus racial climate.*

... one must not look for the gross and obvious. The subtle, cumulative miniassault is the substance of today's racism. . . (Pierce, 1974, p. 516)

In and of itself a microaggression may seem harmless, but the cumulative burden of a lifetime of microaggressions can theoretically contribute to diminished mortality, augmented morbidity, and flattened confidence. (Pierce, 1995, p. 281)

These two epigraphs by psychiatrist Chester Pierce over a 21-year period speak volumes about an important, persistent, and underresearched social problem in the United States: racial microaggressions. Little is known about microaggressions, and yet this subtle form of racism has a dramatic impact on the lives of African Americans. Pierce and his colleagues have defined racial microaggressions as “subtle, stunning, often automatic, and non-verbal exchanges which are ‘put downs’ of blacks by offenders” (Pierce, Carew, Pierce-Gonzalez, & Wills, 1978, p. 66). They further maintain that these “offensive mechanisms used against blacks often are innocuous” and that the “cumulative weight of their never-ending burden is the major ingredient in black–white interactions” (p. 66).

# Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study

Jacob Bor\*, Atheendar S Venkataramani\*, David R Williams, Alexander C Tsai

## Summary

**Background** Police kill more than 300 black Americans—at least a quarter of them unarmed—each year in the USA. These events might have spillover effects on the mental health of people not directly affected.

**Methods** In this population-based, quasi-experimental study, we combined novel data on police killings with individual-level data from the nationally representative 2013–15 US Behavioral Risk Factor Surveillance System (BRFSS) to estimate the causal impact of police killings of unarmed black Americans on self-reported mental health of other black American adults in the US general population. The primary exposure was the number of police killings of unarmed black Americans occurring in the 3 months prior to the BRFSS interview within the same state. The primary outcome was the number of days in the previous month in which the respondent's mental health was reported as "not good". We estimated difference-in-differences regression models—adjusting for state-month, month-year, and interview-day fixed effects, as well as age, sex, and educational attainment. We additionally assessed the timing of effects, the specificity of the effects to black Americans, and the robustness of our findings.

**Findings** 38 993 (weighted sample share 49%) of 103 710 black American respondents were exposed to one or more police killings of unarmed black Americans in their state of residence in the 3 months prior to the survey. Each additional police killing of an unarmed black American was associated with 0·14 additional poor mental health days (95% CI 0·07–0·22;  $p=0\cdot00047$ ) among black American respondents. The largest effects on mental health occurred in the 1–2 months after exposure, with no significant effects estimated for respondents interviewed before police killings (falsification test). Mental health impacts were not observed among white respondents and resulted only from police killings of unarmed black Americans (not unarmed white Americans or armed black Americans).



# Historical perspective on mental health policy and race-based inequity

- Erroneous reporting of mental illness prevalence
  - 19<sup>th</sup> Century: Prevalence of mental illness 10x higher in African Americans residing in free states
  - Argued against abolitionist and emancipation movements
  
- Poor access to care
  - Post Civil War: Segregated custodial care: inaccessible and poor quality
  - 1920s: Insufficient resources to Bureau of Indian Affairs: only 1 hospital in existence for mental health services for American Indians

Starks et al Psychiatric Clinics, 2020



## 20<sup>th</sup> Century Shifts in national policy that influenced equity

- 1946 National Mental Health Act
- 1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act : Care assigned by catchment area contributed to disparities in segregated services and treatment
- 1964 Civil Rights Act, Title VI: prohibited discrimination in federally funded programs
- 1965 Medicare/Medicaid: Prohibited discrimination in federally funded programs



# Policies to address minority mental health

- 1960s: National Advisory Commission on Civil Disorders (**Kerner Commission**)  
**described racism as primary cause of violence** in the US **Joint Commission on Mental Health of Children** defined racism as the primary public health problem in the US
- 1970s African American psychiatrists and mental health professionals advocate → **NIMH establishes Center for Minority Group Mental Health Programs**
- 1980 **Mental Health Systems Act of 1980** (Public Law 96-398): Associate Director of Minority Concerns at NIMH – services and programs for members of ethnic minority groups
- 1985 **Heckler Report** (Health and Human Services) details health outcomes and disparities by race and ethnicity → **HHS Office of Minority Health**



## Policies that influenced equity in mental health

- 1992 Public Law 102 – 321 establishes **NIMH Associate Director for Special Populations**: coordinates research, policy and programs for women and minority populations
- 2001 16<sup>th</sup> US Surgeon General's Report: **Mental Health: Culture, Race and Ethnicity** outlines a strategy for equity in the US health care system
- 2003 IOM's consensus report, *Unequal Treatment*
  - *Improve access to quality care, workforce development, consumer/community engagement*

## Reducing inequity in mental health

- Expand the science base
- Improve access to treatment
  - Integrate mental health and primary care*
  - Ensure language access*
- Reduce barriers to treatment
  - Extend health insurance for the uninsured*
- Improve quality of care
  - Develop and evaluate culturally responsive services*
- Support capacity development
- Promote mental health
  - Address social adversities*
  - Strengthen families*



## Effects on Equity

- Affordable Care Act (2010) and implementation of Mental Health Parity and Addiction Equity Act of 2008
- Parity Act (MHPAEA) – more people likely to be treated for common mental disorders in primary care
  - Mixed effects on equity: Non-Hispanic Black people were less likely to receive care
- ACA expands access significantly for members of racial and ethnic minority groups
- Other ACA outcomes:
  - National Institute on Minority Health and Health Disparities; Offices of Minority Health in multiple HHS agencies



# Drivers of mental health disparities for diverse racial and ethnic groups

- Shortages of mental health professionals
- Culturally divergent beliefs about the causes of mental illness
- Lack of confidence in the formal mental health system
- negative attitudes about psychiatric treatment
- Limited English proficiency



## Trends in disparities

- Between 2004 and 2012, racial-ethnic disparities in accessing mental health care increased in the United States
  - increased access to psychotropic medicine among whites,
  - high uninsured rates among members of racial ethnic minority groups
  - difficulty detecting psychiatric distress among some members of minority groups



## What is access to care?

- Complex set of attitudinal, behavioral, and resource-related factors, including availability, accessibility, affordability, and acceptability of health services as well as accommodation of services to patients' needs
- Racial/ ethnic disparities exist among high and low users of mental health services and much of the disparity appears to stem from lack of initial access to mental health services



## Inclusion and exclusion criteria

- Racial-ethnic minority groups residing in the United States
- Study design used an intervention that sought to improve the initiation of mental health care
- Study examined outcomes related to initial access
  - New appointments with a mental health care provider
  - Willingness to initiate medicine or psychological interventions
- 29 studies through 2016



# Cultural Adaptation

23 of 29 studies used cultural adaptation

- Incorporating feedback from participants from members of diverse racial-ethnic groups on intervention
- Hiring culturally and linguistically compatible interventionists
- Using images and phrases that fit participants' cultural context
- Training providers in cultural sensitivity



# Cultural Adaptation

- Meeting practical needs (such as appointment reminders and transportation)
  - Modifying the intervention to align with participants' conceptualization of mental health
- 20 of the 22 studies that did not demonstrate reduction in disparities used varying degrees of cultural adaptation



## Policy interventions

- Medicare Part D implementation removed restrictions on the number of reimbursable prescription medications that Medicare enrollees could receive per month
- **Disparities** in the receipt of antidepressants between African Americans and whites **increased** in states that removed drug caps because of increased receipt of antidepressants among nonelderly white patients



## Screening and referral studies

- Social workers and primary care providers were trained to screen for depression in nursing homes and primary care clinics
- Screening reduced disparities in receipt of antidepressants between African-American and white older adults



# Psychoeducation

Aimed to

- Educate patients about psychotherapy entry and attendance
- Improve depression or psychosis literacy
- Reduce stigma associated with antidepressants,
- Increase access to help seeking or available mental health resources



## Psychoeducation outcomes

- Improved the frequency with which patients raised concerns about treatment and discussion of ethnic, cultural, and religious issues
  - Improved knowledge about depression or psychoses
  - Reduced stigma associated with antidepressants
  - Improved attitudes about depression treatment
  - Increased participants' willingness to recommend seeking professional mental health services
- No comparison group to measure disparities reduction



# Colocation of mental health services

## PRISMe study

- Integrated care intervention vs. enhanced referral model
- Integrated care intervention: assessment, care planning, counseling, case management, psychotherapy, and pharmacological treatment.
- Latinx and African Americans: intervention group were more likely to seek mental health providers than control counterparts
- Caucasians: no change in seeking mental health care by treatment condition.
- Asians: intervention group significantly less likely to initiate mental health care compared to control counterparts

Ayalon et al, 2007; Areal et al 2008; Bartels et al 2004



## Colocation - 2

- Providing telepsychiatry at a community health center increased mental health appointments, antidepressant use, and willingness to pay for telepsychiatry among Latinx clients
- A school-based youth suicide prevention program - school staff as crisis team members improved help seeking from community mental health services;
  - Latinx students were less likely than non-Latinx students to seek care from community mental health services
  - No racial-ethnic difference in the use of school-based mental health services.



## Collaborative Care

- Partners in Care randomized trial of CC for depression in primary care
  - Improvements in quality of care for depression
  - Improved mental health quality of life after 2 years and 5 years
  - African American and Latinx participants had greater improvements
- IMPACT study (CC for older adults) -African Americans receiving intervention improved initiation of psychotherapy
- 4 of 7 collaborative care studies yielded greater initiation of treatment compared to usual care



# Summary

- 7 of 29 studies provided evidence of improved outcomes and disparities reduction in initiation
  - screening and referral
  - colocation of primary care and mental health services
  - collaborative care interventions
- 6 of 7 that reduced disparities used integrated care models



## Why might this be?

- Practical convenience
- Privacy in seeking care for mental illness
- Greater diversity of providers in primary care settings



## There's more to it

- Access to care involves understanding complex interactions

Context

Illness characteristics and course

social networks

systems of care

- Multi-level factors predict disparities (individual, neighborhood, and policy levels)



## Multilevel factors interact to influence care initiation

- Being educated
  - living in an urban area
  - being female
  - having mental and general medical complaints
- all predict greater initiation of care



# Multilevel factors interact to influence care initiation

- Being Black or Latinx
  - being publicly insured
  - Not being a citizen
  - Being healthier
- Predict less initiation



## What more can we do?

- Include voices of people from diverse ethnic groups in these studies
- More evidence on how multilevel interventions to address disparities change initiation as well as outcomes
- Ensure that clinicians understand why and how systemic racism influences decisions to seek care or avoid care.