

*The following is the first in a series on mental health in the mainstream of public policy, a research agenda focusing on significant areas of public policy for which individuals with mental disorders create special opportunities and challenges. Each commentary identifies key issues in a specific area and discusses potential research to increase understanding of these issues.*

## Mental Health in the Context of Health Disparities

**A** longstanding theme of mental health policy has been the tension between the integration of mental health into general health policy and exceptionalism. Integration is represented by policies such as parity in health insurance coverage, and exceptionalism by “carve-outs” of mental health care to behavioral health care organizations. Frank and Glied (1) have argued that policies based on exceptionalism in mental health are waning and that integration has had salutary effects on persons with mental illness through mainstreaming into general social and health programs (notably Medicaid).

Mental health status and mental health care disparities can also be framed within the exceptionalism/integration debate, in both a traditional and new sense. In the traditional sense, one may question whether policies promoting general purpose interventions to reduce health status or health care disparities will also address disparities in mental health. In the new sense, one may question whether policies should differ when poor health status or poor health care is correlated with certain racial groups. Should we take an integrationist perspective and address poor health status and low quality of care in general or take an exceptionalist perspective and promote policies focused on disparities? From a health policy perspective, disparities in health status or health care may not deserve special focus over and above the problems of poor health status and poor quality of care in general. Concern for social justice, however, argues for a focus on disparity. For example, the goal of equal opportunity is to provide a social environment in which no one is excluded from the activities of society, such as education, employment, or health care, on the basis of immutable traits.

### Health Status and Health Care Disparities

No consensus exists for defining and measuring health status disparities (2). The definition we use in this article is that any inequality in health due to social factors or allocation of resources is unjust and, therefore, constitutes a disparity. Included as part of the definition of a health disparity between races are health status differences due to higher rates of poverty, such as poor nutrition.

Similarly, no consensus exists about what constitutes a health care disparity. We agree with the Institute of Medicine’s report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” (3), which defines disparity as any difference in health care quality not due to differences in health care needs or preferences. As such, disparities can be caused by a range of social factors, including inequalities in access to good providers, differences in insurance coverage, or discrimination by professionals in the clinical encounter.

#### **Brief Review of Disparities**

Health and mental health disparities are embedded within persistent socioeconomic differences. Large differences among the major racial groups exist in terms of income, and even more so in terms of wealth. In 2004, minorities’ incomes were about 56% of that of their white counterparts; however, their net worth (assets minus debts) was only 27% of that of their white counterparts (4). Not surprisingly, large differences in access to health care also exist among these groups. All minority groups are less likely to be covered by health insurance than their white counterparts. Broad patterns of socioeconomic disparities by race exist in many levels of American life.

**Disparities in health status.** Despite the well-known unreliability of ethnic designations noted on death certificates, the most meaningful summary measure of health status disparities is life expectancy, driven by differential mortality among ethnic groups. Table 1 shows disparities in age-adjusted and age-specific death rates for white and minority populations. Black and American Indian/Alaskan Native populations have elevated rates of mortality compared with white Americans. On the other hand, Asian Americans have significantly lower mortality rates. Finally, Hispanic Americans have advantages early and late in life but are at a disadvantage from ages 15 to 34 (5).

**TABLE 1. Overall Age-Adjusted Mortality Rates for 1998–2000 and Age-Specific Death Rates for 2000<sup>a</sup>**

Age (years)	Non-Hispanic White Population	Black/White Population Ratio	American Indian/White Population Ratio	Asian and Pacific Islander/White Population Ratio	Hispanic/White Population Ratio
All ages	85.50	1.3	0.9	0.6	0.8
1–4	2.79	2.0	2.0	0.7	1.0
5–14	1.72	1.5	1.0	0.5	1.0
15–24	7.21	1.9	1.7	0.6	1.3
25–34	9.26	2.2	1.8	0.6	1.1
35–44	17.97	2.1	1.7	0.5	0.9
45–54	39.31	2.1	1.3	0.5	0.8
55–64	96.00	1.8	1.2	0.6	0.8
65–74	240.94	1.4	1.0	0.6	0.7
75–84	572.87	1.2	0.7	0.6	0.6
≥85	1582.64	0.9	0.4	0.6	0.6

<sup>a</sup> Rates per population of 10,000. Age-adjusted mortality rates and age-specific death rates from the National Center for Health Statistics (2003 and 2004, respectively). Table adapted from Williams DR: The health of U.S. racial and ethnic populations. *J Gerontol B* 2005; 60B:53–62. Copyright © 2005 The Gerontological Society of America. Reproduced with permission.

Future health disparities are likely to be driven in part by the differential rates of obesity currently found among young minorities because of the associated health risks, including heart disease, type 2 diabetes, high blood pressure, stroke, arthritis-related disabilities, sleep disorders, and cancers of the breast, prostate, and colon. Although 30% of men across racial groups are obese, African American and Latina women have rates of obesity of 51.6% and 40.3%, respectively, compared with a rate of 31.5% for white women (6).

**Disparities in health care.** The quality of health care in the United States for all ethnic groups is far from ideal. A major gap exists between recommended care and what is delivered. Nationally, medical patients receive only 54.9% of recommended care (7). Evidence of racial and ethnic disparities in health care is almost uniformly consistent across a range of illnesses and health care services (for an exception, see reference 8). Disparities have been clearly documented in cardiovascular care (9–12); cancer diagnostic tests (13) and treatments (14); HIV antiretroviral therapy (15), prophylaxis for pneumocystic pneumonia, and protease inhibitors (16); diabetes care (17); and end-stage renal disease and kidney transplantation (18, 19). Over time, disparities appear to have diminished slowly for black Americans, but the majority of disparities for quality and access have widened for Hispanic Americans (20).

**Disparities in mental health status.** Mental health status disparities exhibit a decidedly different pattern than do health disparities. The findings in Table 2 all derive from the Collaborative Psychiatric Epidemiology Survey program funded by the National Institute of Mental Health (NIMH), which used common core questions and unified sampling weights (21). Hispanic Americans (with the exception of those from Puerto Rico), Asian Americans, and black Americans have fewer mental disorders than do white Americans (22–24). For Mexican, African, and Caribbean immigrants, rates of disorders increase with time spent in the United States (25, 26). Similarly, compared with a nationally representative sample of the U.S. population, American Indians are at

**TABLE 2. Prevalence of Lifetime and Past-Year Psychiatric Disorders According to Race/Country of Origin**

Race/Country of Origin	Lifetime Disorders <sup>a</sup>		Past-Year Disorders <sup>a</sup>	
	%	SE	%	SE
Latino American <sup>b</sup>				
Puerto Rican	38.98	3.15	22.88	2.20
Cuban	28.38	1.68	15.91	1.31
Mexican	28.42	1.58	14.48	1.16
Other Latino	27.29	2.32	14.42	2.07
Asian American <sup>c</sup>				
Chinese	18.00	2.34	10.00	1.73
Filipino	16.74	1.40	8.99	1.26
Vietnamese	13.95	2.40	6.69	1.38
Other Asian	18.29	2.81	9.55	1.56
Black American <sup>d</sup>				
African American	30.54	1.07	14.79	0.78
Black Caribbean	27.87	1.76	16.38	2.24
White American <sup>e</sup>	37.37	0.59	19.00	6.48

<sup>a</sup> Psychiatric disorders include major depressive disorder, dysthymia, agoraphobia, social phobia, generalized anxiety disorder, post traumatic stress disorder, panic disorder, drug abuse, drug dependence, alcohol abuse, and alcohol dependence.

<sup>b</sup> From Alegría et al. (22).

<sup>c</sup> From Takeuchi et al. (23).

<sup>d</sup> From Williams et al. (24).

<sup>e</sup> From Kessler et al. (30).

heightened risk for posttraumatic stress and alcohol dependence, but at lower risk for depression (27). However, more black Americans may have schizophrenia, a rare but very serious condition, than white Americans (28–31). While substantial evidence exists to suggest that clinicians overdiagnose schizophrenia and underdiagnose mood disorders in African Americans (32), clinical decisions do not account for all of the observed differences.

Although minorities have fewer psychiatric disorders than do white Americans, both black and Hispanic Americans are more likely to be persistently ill (33). Similarly, depression is more likely to be chronic, severe, disabling, and untreated among black Americans compared with white Americans (34).

**Disparities in mental health care.** Most research comparing mental health care across ethnic groups finds evidence of disparities in access, use, and quality of care. As documented in “Mental Health: A Report of the Surgeon General” (35) and its supplement, “Mental Health: Culture, Race, and Ethnicity” (36), members of racial and ethnic minority groups have less access to mental health services than do their white counterparts, are less likely to receive needed care, and are more likely to receive poor quality of care when treated. Minorities in the United States are more likely than white Americans to delay or fail to seek mental health treatment (37–40). Two studies examining trends in mental health care, using the Institute of Medicine definition of disparities (41, 42), found no progress toward eliminating disparities in mental health care provided in either primary care or psychiatric settings.

## Causes of Health and Mental Health Care Disparities

Health and mental health care disparities are highly associated with access in general and lack of insurance in minority communities (43). In addition, both geographic and provider-level differences are major sources of disparity (44). Minorities are often overrepresented in inner cities with poor access and quality of care. Disparities may also occur at the provider level, with minorities overrepresented in practices providing low-quality care.

Health and mental health care may differ in the impact of providers on disparities. Specifically, physicians tend to hold a prior belief about the likelihood of a patient having a condition and update this belief according to the strength of information received in the clinical encounter. Because the prevalence of mental disorders may be slightly

lower in minorities, underlying assumptions about the distribution of disease or communication problems between the physician and patient can lead to discrimination. This provider discrimination has been documented in two studies of mental health care (45, 46), in which clinicians responded with less alacrity to variation in severity of depression among minority patients than white patients, implying that clinicians are less able to “read” severity among minorities. Disparities arising within the clinical encounter may be more important in mental health care than in health care.

Low treatment rates in minority populations are likely related to poor minority representation in the health care workforce. Ethnic minorities are even more poorly represented in mental health care than in health care in general (Table 3). Because of the greater need for cultural sensitivity in dealing with mental health issues, extensive issues of trust, and the increasing language barrier between provider and patients, disparities in the workforce may account for more disparities in mental health than general health care. Disparities in mental health professionals also likely contributes to the inadequate representation of minorities in research, including in important clinical trials.

**TABLE 3. Percentage of U.S. Mental Health Care Workforce According to Race**

Race	Total U.S. Population <sup>a</sup>	Physicians <sup>b</sup>	Psychiatrists <sup>c</sup>	Psychologists <sup>c</sup>	Social Workers <sup>c</sup>
White	67.0	77.0	81.0	93.0	92.0
Hispanic	14.0	4.0	5.0	3.0	3.0
Black	13.0	5.0	3.0	2.0	4.0
Asian	5.0	14.0	11.0	2.0	1.0
American Indian/Alaskan Native	1.5	0.1	0.1	0.3	0.2

<sup>a</sup> 2005 U.S. population data from U.S. Census Bureau.

<sup>b</sup> 2005 physician data from the American Medical Association. Percentages are for those with a designated race.

<sup>c</sup> 2002 psychiatrist, 2004 psychologist, and 2004 social worker data from the Substance Abuse and Mental Health Services Administration. Percentages are for those with a designated race.

## Public Policies for Eliminating Health and Health Care Disparities

We now turn to the question of whether mainstream policy can reduce mental health status and health care disparities.

### *Policies to Address Disparities*

To eliminate health status disparities, progress against social disparities (e.g., education, housing, job opportunities, etc.) is likely to be most important (47). Mental health, in which health status disparities are not evident, presents an interesting paradox in this respect. While addressing social disparities may be important in its own right and in terms of reducing general health disparities, emphasizing social factors as a means to deal with mental health disparities seems less indicated. In contrast to general health, focus on mental health care appears to be more important for addressing disparities. For example, black Americans have lower rates of lifetime depression than their white counterparts living in similar areas, but rates of depression in the past year only are similar, and black Americans are more likely to rate their depression as severe and disabling (34). Quality mental health care could potentially eliminate these disparities.

In the case of mental health care, policy approaches share features with general health care policy. In fact, the major recommendations for eliminating health care disparities from the Institute of Medicine’s report (3) appear equally applicable to mental health care, including taking steps to improve access to care and providing economic incentives for improving patient-provider communication and trust, as well as rewarding appropriate screening, preventive, and evidence-based clinical care. Further, policies to increase minority participation in the health care workforce would most likely improve disparities in mental health care, as provider-patient communication and common language is particularly important and in which the minority workforce is particularly lacking.

### *Policies Designed to Improve the Quality of Care*

Should quality improvement efforts be focused on low quality or, since quality is lower for minorities, should care for minorities get special attention? Two studies have looked at interventions designed to improve quality of mental health care and examined minority outcomes. These studies were conducted in primary care settings, where ethnic minorities are most likely to receive mental health care. In a large trial of quality improvement for depression in older patients, a collaborative care intervention similarly improved the quality of care provided to African American, Hispanic, and white patients (48). A similar study of two quality improvement interventions for depression in managed care settings found that clinical outcomes at 1 year were better for Latino and African American patients than for white patients (49). Five years later, the interventions were found to improve disparities by improving health status outcomes and unmet need for care more among minorities than white patients (50). General mental health care improvements may help to decrease disparities, especially if efforts are made to make the quality improvement interventions appropriate for ethnic minorities.

### *Research to Decrease Disparities*

A major priority for research is finding solutions to eliminate mental health care disparities. Public awareness campaigns and direct-to-consumer advertising may do little to improve disparities. On the other hand, quality improvement interventions have been shown to decrease disparities in depression care for some minority groups initially experiencing lower quality of care. Determining the effectiveness of such interventions in other mental disorders (e.g., bipolar disorder, anxiety, and schizophrenia), other populations (e.g., Asian American and American Indian/Alaskan Native), and other care settings (e.g., mental health specialty) will be important. If this finding is robust, public policy emphasizing general quality improvement interventions could help reduce disparities.

Racial minorities have equal or better mental health than do white Americans, despite lower socioeconomic status and higher levels of social problems. Research to understand the protective role of cultural factors could benefit everyone. Understanding how culture protects mental health but not physical health in the presence of poverty, particularly for African Americans, could help answer fundamental questions about the impact of culture on health. Similarly, monitoring the patterns of worsening mental health status for minorities according to time spent in the United States could be important to understanding negative environmental influences on mental health in the United States.

Improving the representation of minorities in the health and mental health care system is needed. Evaluation of innovative programs to increase interest in health and mental health care among minorities would be an important step toward eliminating disparities. Similarly, understanding the impact of minority-focused mental health clinics on access and quality of care for minority populations will be important for building an appropriate policy to overcome mental health care disparities.

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