

# **Mental Health Services in Primary Care Settings for Racial and Ethnic Minority Populations**

**ISSUE BRIEF**

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## Executive Summary

Disparities in mental health care for racial and ethnic minority populations have been well documented. Although seminal reports are inspiring a new group of studies and papers that focus on the scientific, clinical, and policy issues surrounding these disparities, much remains to be done. The President's New Freedom Commission on Mental Health (NFCOMH) (2003) concluded that behavioral health systems in the United States are fragmented, fraught with barriers and leaving too many people seeking mental health care, with unmet needs. This is particularly true for minority populations who are often over represented in our nation's most vulnerable populations, such as the poor, the uninsured, the homeless, and the incarcerated. Unfortunately, services are not coordinated therefore making it difficult for minorities to access services.

Poverty is associated with higher rates of mental health problems, and for racial and ethnic minorities, there is little access to needed mental health services, regardless of location or point of entry. Frequently minorities wait until acute symptoms occur and seek services in hospital emergency rooms where they are stabilized and then sent home. Lack of access to a full range of mental health services also results in higher rates of incarceration. For those who do receive mental health services, the appropriateness and quality of the interventions is highly variable. The Surgeon General's Report on Mental Health: Race Culture and Ethnicity (2001) and The Institute of Medicine Report: Unequal Treatment (2003) describe that racial and ethnic minorities experience lack of access and are often misdiagnosed and receive inadequate treatment. Continued unmet needs and the provision of substandard mental health services to minority populations can only lead to a negative impact on the well being of our nation—with both costly economic and negative social consequences.

Primary care settings are the first point of contact and the treatment site of choice for all Americans, particularly racial and ethnic minority, and those with low incomes and mental health problems constitute upwards of 40% of patients' presenting complaints in primary care. Primary care is more available and easier to access than specialty behavioral health and many consumers view mental health treatment in primary care settings as less stigmatizing than care received in specialty behavioral health settings. The growing recognition of the important role of primary care settings in the delivery of mental health services for minorities is noteworthy, particularly those with a system integration of health with behavioral health specialists. The NFCOMH makes a strong case for mental health being part of health in its first goal. But more needs to be done to establish parity with an understanding that physical and behavioral health is intrinsically linked.

Making behavioral health services available and utilized by racial and ethnic minorities will require coordinating and integrating supports and services needed for those with mental health and/or substance abuse disorders needs, and must take into consideration the modality, costs, and location. It will require that we embrace a change in our thinking about health in general. Minority and bilingual providers will need to be trained, recruited into the workforce and retained. Cultural nuances, protective and risk factors, and biases (stigma) must be understood, respected and taken into consideration when developing access points for services, in addition to developing new approaches to outreach, education and communication.

# Recommendations

This issue brief provides an overview of the provision of mental health interventions in primary care settings for racial and ethnic minority populations; outlines strengths and challenges, and submits the following recommendations:

## **Recommendation 1:**

The Office of Minority Health, Office of Public Health and Science/OS, in its leadership role with the HHS Disparities Council, should assure that the nexus between physical and behavioral health become a primary focus of attention, and will ensure that mental health becomes a public health priority. Designate Mental Health as a health disparity category.

## **Recommendation 2:**

Establish effective policies that create and build a competent minority healthcare and mental health workforce throughout the country.

## **Recommendation 3:**

Improve measurably, the knowledge base of behavioral health treatments for racial and ethnic minority patients/consumers. There is a growing knowledge about the etiology and typology of mental health and substance abuse disorders, and their comorbidities, along with improvements of effective interventions for the overall population. However, less is known about evidence based interventions and best practices for minority populations. Because of this, translational research can be very effective. Adapting current best practices while simultaneously developing new practices (pharmacological, psychosocial and psychotherapeutic) is needed. And although the body of literature on mental health conditions and treatments requires continuing expansion, this approach can supply an essential knowledge base for those providing mental health services.

## **Recommendation 4:**

Coordinate efforts designed to increase the number of service models that integrate mental health and primary health care services targeted in predominantly low-income and minority communities. Due to a variety of reasons, racial and ethnic minorities seek and receive behavioral health care more often from primary care providers. This may be due in part to culturally embedded help seeking behaviors and beliefs, but also because mental health concerns were not the primary reason for the medical consultation. Regardless, primary care providers are less prepared to accurately recognize, diagnose, and treat behavior health problems. Co-location of providers and resources is one example of how to increase access and quality of care, and lowers treatment costs

## **Recommendation 5:**

Develop culturally sensitive and linguistically competent mechanisms to combat stigma. Mental Health, a Report of the Surgeon General (DHHS, 1999) asserted that low levels of funding and limited attention to the mental health agenda was in itself due to stigma. Strategic public health messaging is powerful, especially when coupled with policies and is evidence based. Much needs to be done to debunk the mythology surrounding mental health and illness, especially with regard to the underpinnings, treatments and potential for recovery. This is particularly cogent for racial and ethnic minorities who tend to grossly underutilize needed mental health services.

# Mental Health in Primary Care Settings for Racial and Ethnic Minority Populations

## Background:

Almost sixty years ago, the World Health Organization (WHO) defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This definition opened the window to an increased recognition of the human as a holistic being; of mind, body and spirit, and propelled the need to better understand the interrelationship between physical and mental health.

The cost of mental illness is widespread, pervasive, and disabling for individuals, families and for society as a whole. In the United States, one person in four has been diagnosed with a mental disorder in the last 12 months and is consequently in need of services (The WHO World Mental Health Survey Consortium, 2004).

Loss in worker productivity due to mental illness is also widespread. The U.S. National Comorbidity Survey (Kessler et al., 1992) reported a total of one million lost days of productivity due to mental illness. This equals approximately \$105 billion in estimated lost revenue, not including high medical and pharmaceutical bills. The National Mental Health Association (NMHA, 2001) suggests that increasing the amount spent on the prevention and treatment of mental illness by just 5.5% would cut the losses in half. Prevention strategies could bring a potential savings of over \$56.5 billion for the entire U.S. economy.

Despite the high need for mental health service provision, people often go untreated. The cost of untreated mental illness and addictive disorders is estimated at \$113 billion annually (Labor Day Report, 2001). Depression alone is now the second-leading cause of disability worldwide, and brings as much loss in functioning as most chronic diseases, such as diabetes or heart disease (RAND, 2004; Global Burden of Disease, 1990). Moreover, minority populations bear a greater burden of unmet mental health needs and thus suffer a greater loss to their overall health and productivity (DHHS, 2001).

Persistent racial and ethnic disparities in health care have long been recognized as a national concern. In 1999, the first-ever Report of the Surgeon General on Mental Health (DHHS) was issued, followed by the groundbreaking supplement, *Mental Health: Culture, Race and Ethnicity* (DHHS, 2001). More recently, the Institute of Medicine's landmark report on *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* provided extensive evidence that racial and ethnic minorities have less access to health care and are more likely to receive lower quality health services than White Americans (Institute of Medicine, 2002). The findings from these reports and others have inspired a new group of studies and papers that focus on the scientific and clinical, as well as pertinent policy issues surrounding mental health disparities.

Minority populations are often over represented in our nation's most vulnerable populations, the poor, the uninsured, the homeless, and the incarcerated; they have little access and/or may under

underutilize mental health services. And, for those who do receive mental health interventions, the appropriateness and quality of those treatments remain in question. These unmet needs and provision of poor quality mental health services to minority populations is impacting the well being of our nation.

A constellation of barriers to seeking and receiving outpatient mental health care among racial and ethnic minorities has been well documented (Duran et al, 2004; Kleinman, 2004; Snowden & Pingitore, 2002; Vega et al., 2001; U.S. Department of Health and Human Services, 2001). Some of these barriers include:

- high costs and/or lack of health insurance
- poor quality of care
- lack of knowledge of where to receive care or lack of transportation
- little focus on preventive care
- few racial/ethnic/bilingual minority mental health providers
- lack of culturally and linguistically competent care
- clinician bias in diagnosis and treatment
- consumer help seeking behaviors
- lack of consumer knowledge of available resources
- stigma

## **Changing Systems of Care for Mental Health**

### *Specialty Mental Health*

President Bush's New Freedom Commission on Mental Health (2003) concluded that behavioral health systems in the United States are fragmented, leave too many with unmet needs and are fraught with barriers to mental health care. Limited availability of and access to mental health specialists also remains a serious problem in many places, particularly in rural environments.

The New Freedom Commission identified six goals that need to be achieved in order to affect the complete transformation of the mental health system envisioned. These goals are that:

- **Americans understand that mental health is essential to overall health**
- Mental health care is consumer<sup>1</sup> and family driven
- **Disparities in mental health services are eliminated**
- Early mental health screening, assessment, and referral to services become a common practice
- Excellent mental health care is delivered and research is accelerated
- Technology is used to access mental health care and information.

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<sup>1</sup> Term frequently used to describe an individual who has and/or is recipient of mental health services; interchangeable with patient.

Transforming the behavioral health system will require integrating the supports and services needed for persons with mental health needs, with substance abuse disorders, or both, into the mainstream of public and private sector systems. It will demand that behavioral health care be supported by a host of providers and payers from both the public health and social services arena, such as education, criminal justice, labor, housing, and child welfare. A change will need to fully integrate a consumer perspective and approach; one that not only recognizes the deficits and disparities, but one that builds upon assets and strengths—fostering resilience.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends an approach that suggests a '*Life in the Community for Everyone*'. This refers to an approach that works with and builds upon natural support systems like the family, church, schools, and businesses. This is especially poignant for racial and ethnic minorities as they tend to be overrepresented among the most vulnerable populations and underrepresented among providers.

Over the past decade, the specialty mental health system has undergone substantial changes in the organization, delivery, and financing of care. As with other medical specialties, most psychiatric services, private and public, have increasingly shifted all mental health and substance abuse treatment services into some form of fee for management. Technological and treatment advances and changes in the organization, delivery, and financing of mental health care have all contributed to the changing role that psychiatrists play in existing systems of care. Additionally, downward trends in the number and demographics of medical students who choose psychiatry as a specialty have begun to alter the size and composition of the workforce, particularly impacting the number of racial and ethnic minorities in the field (SAMHSA, 2004).

According to the report from the Yearbook of Managed Behavioral Health Market Share in the United States, 1999- 2000, the majority of insured Americans are enrolled in some form of managed behavioral health plan (Findlay, 1999). Medicaid funds more than half of public mental health services administered by the States, and is now the largest source of revenue for community mental health providers. However, those without health insurance, or those who exhaust their coverage, are often unable to get the services they need (National Council on Disability, 2002). Table 1 shows the overall rates of uninsured by race and ethnicity for 2003

**Table 1: People without Health Insurance Coverage, 2003**

<b>Uninsured Population, Race and Ethnicity</b>	<b>Overall Rates of Uninsured, %</b>
Total People	15.6
Non- Hispanic, White	11.1
African American	19.5
Latino/Hispanic	32.7
American Indian/Alaska Native (Three-year average, 2001-2003)	27.5
Asian American	18.8

Source: <http://www.census.gov/prod/2004pubs/p60-226.pdf>, Table 5 and Release/[www/releases/archives/income.wealth/002484.html](http://www/releases/archives/income.wealth/002484.html)

The relationship of race and ethnicity to mental health care delivery is complex, and the use of mental health outpatient services varies with race/ethnicity, gender, age and income (SAMHSA, 2003). Both negative and positive experiences in the healthcare system can profoundly impact seeking, receiving and further utilizing services. Although racial and ethnic minorities have increased their utilization of mental health interventions overall, Whites were more likely (12.0 percent) to have received treatment than African Americans (6.8 percent), or Latinos (6.5 percent). American Indians and Alaska Natives (AIAN) were more likely than persons from any other racial/ethnic group to have received mental health treatments in a specific time frame (15.5 and 15.1 percent, respectively). And, rates were lowest among Asian Americans (3.1 percent) and Native Hawaiians and Pacific Islanders (4.4 percent) (SAMHSA, 2003).

A key finding in the Surgeon General’s Report on Mental Health: Culture, Race and Ethnicity (2001) was that living in poverty has the most measurable effects on the rates of mental illness. Racial and ethnic minorities are overrepresented among the poor, and people in these lowest socioeconomic positions are at least 2-3 times more likely than those in the highest positions to experience a mental disorder. Racism and discrimination are highly stressful and can adversely affect health and mental health.

In 2003, the overall rate of poverty among most racial and ethnic minority groups in the U.S. is much higher, than that of non-Hispanic Whites, as illustrated in Table 2.

**Table 2: Rate of Poverty, U.S. 2003**

<b>Population, Race and Ethnicity</b>	<b>Poverty Rate %</b>
Non- Hispanic, White	8.2
African American/Black	24.4
Asian American	11.8
Hispanic/Latino	22.5
American Indian/Alaska Native (Three-year average, 2001-2003)	23.9

Source: <http://www.census.gov/prod/2004pubs/p60-226.pdf>

With advances in research, the causes and evidence-based treatments of mental illness are better known today than ever before. According to recent reports, the great majority of mental illnesses are treatable. In fact, some findings indicate that 80 percent of patients with depression can now recover (NIMH, 2004). With treatment and recovery more of a reality, everyone regardless of age, sex, religion, race, ethnicity, primary language or national origin should have the right and access to evidenced-based mental health services.

#### *Mental Health in Primary Care Settings*

Overall, racial and ethnic minority consumers receive mental health care interventions in primary care settings (Duran et al, 2004; Kleinman, 2004; Snowden & Pingitore, 2002; Vega et al., 2001). And, primary care settings, as the initial point of contact for physical health problems, can play a critical role in identifying individuals with undiagnosed or untreated mental disorders and for removing barriers to treatment. In addition, clinical practices that respect the cultures and languages of the people they serve may be more successful in encouraging minority populations to utilize services and ultimately receive appropriate care.

Primary care is often easier to access than specialty mental health services. This is particularly salient with managed care, and the use of primary care physicians for referrals to specialists, as patients must first utilize the primary care setting, but also true for the uninsured. In addition, many consumers view mental health treatment in primary care settings as less stigmatizing than treatment received in specialty mental health settings. On the average, 67% of psychotropic agents and 80% of anti-depressants are prescribed by primary care physicians. As a result, consumers are more likely to seek diagnosis and treatment for mental health disorders from their primary care provider (Grantmakers in Health, 2003; Snowden & Pingitore, 2002).

The prevalence of mental disorders in primary care (25%) is somewhat higher than what is seen in the general population, twenty percent of whom are affected by mental disorders each year (Grantmakers in Health, 2003). And because the majority of racial and ethnic minorities present first to a primary care physician for mental health problems, primary care is an ideal setting for both the identification and treatment of these problems. Mental health conditions such as depression, anxiety, drug and/or use and dependence, sleep problems, chronic fatigue, and other

unexplained somatic symptoms are both prevalent and amenable to treatment, particularly when identified early.

Because of the lack of access to preventive care, early identification and lack of quality interventions, the service needs of minorities may exceed those of Whites. Poverty, lack of, or insufficient medical insurance together with a higher concentration in inner-city areas with high poverty levels or, alternatively, in isolated rural and frontier areas hamper access to care, often leading to more chronic mental health conditions.

Federally-funded Community Health Centers serve as the family doctor to 15 million Americans who are predominately underserved, minority and poor. They are required to serve all members of a community, regardless of ability to pay. As the largest national network of primary care safety net providers, health centers strive to reduce and eliminate health disparities. As such, they are uniquely posed to serve millions of those with unmet behavioral health needs. Some centers report at least 50-70% of their patients have a behavior health disorder, and that in some cases behavior health is the primary reason for the visit.

In a recent report titled: 'Health Centers' Role in Answering the Behavioral Health Needs of the Medically Underserved (2004), Community Health Centers (CHC) are reported to be the primary care providers to 15 million medically underserved individuals. They have become critical sources of behavioral health services to those most vulnerable, particularly minority populations, the poor and the uninsured. According to the 2003 CHC Uniform Data System, health centers reported 2.1 million encounters for mental health conditions and 720,000 contacts for drug or alcohol dependence (Proser & Cox, 2004).

The Indian Health Service (IHS) is an integrated health care system that provides valuable mental health services to American Indians and Alaska Natives (AIAN) through their Mental Health and Social Services program. This program is community oriented, clinical and preventive —providing care to over 1.6 million consumers, both urban and reservation based. Nevertheless, the accessibility of mental health and substance abuse treatments continue to be a problem. Proven and Carle (2000) found the greatest unmet needs for adult AIANs to include substance abuse and mental health out-patient counseling services.

Acute and chronic health conditions greatly impact on the emotional well being of the AIAN populations, and conversely, behavioral health impacts upon one's physical health status (Duran et al, 2004; IHS, 2004). Several of the top ten mortality and morbidity problems for AIAN are either directly related to or significantly impacted by behavioral and/or lifestyle choices. Yet, despite these and other outstanding behavioral health needs, mental health and social services are grossly underfunded, with the current year budget accounting for less than 5% of the overall IHS costs (IHS, 2004). And although the majority of AIANs actually live in urban areas, as little as 1% of the IHS budget is targeted for urban Indian programs (Commonwealth Fund, 2004).

The advantages of primary care settings for the diagnosis and treatment of mental disorders are well documented, yet primary care providers vary greatly in their capacity to recognize and diagnose mental health disorders, and are often ill-equipped to offer comprehensive or integrated services. In fact, about half of all patients with mental disorders go undiagnosed in primary care

settings (Kessler et al, 2001). There is additional concern about primary care physicians maintaining diagnostic accuracy for mental disorders, even after continuing education courses (Kroenke, Taylor-Vaisey, Dietrich & Oxman, 2000).

Specifically, minorities are likely to be poor, without medical insurance, and concentrated in inner-city areas with high poverty levels or, alternatively, in isolated rural and frontier areas with fragile, often poor economic structures (SAMHSA, 2004). As a consequence, they are most likely to be exposed to high stress levels that may result in an elevated need for mental health services. Because few private services are available to them, minority populations are more dependent on public health and mental health services, and continue to utilize outpatient settings for their mental health care. As the medical sector continues to serve as a primary point of entry for many underserved racial and ethnic minority populations, the creation of critical linkages between medical providers and existing mental health services is warranted.

### Disparities in Mental Health Care

The United States population is composed of many diverse groups. Evidence indicates a persistent disparity in the health status of racial and ethnic minority populations, as compared with the overall health status of the U.S. population.

Over the next decade, the composition of the U.S. will continue to become more racially and ethnically diverse, thereby increasing the demand for providers of mental health services to provide effective interventions tailored to specific community needs, having significant consequences for the need and demand for providers of mental health services. Poverty, lack of adequate access to quality health services, few culturally and linguistically competent health providers and services, and lack of preventive health care are all factors that must be addressed. Table 3 shows current and projected population by race and ethnicity, years 2000, 2010 and 2050.

**Table 3: U.S. Population by Race/Ethnicity: 2000 and Projected 2010 and 2050**

<b>U.S. Population, Race/Ethnicity</b>	<b>Percentage (%) 2000</b>	<b>Projected % 2010</b>	<b>Projected % 2050</b>
White, non Hispanic	69.4	65.1	50.1
African American/Black	12.7	13.1	14.6
Hispanic/Latino	12.6	15.5	24.4
Asian/Pacific Islander	3.8	4.6	8.0
American Indian/Alaska Native	1.5	Unavailable	Unavailable

Source: <http://www.census.gov/Press-Release/www/releases/archives/population/001720.html> and <http://www.census.gov/prod/2002pubs/c2kbr01-15.pdf> and <http://www.census.gov/ipc/www/usinterimproj/natprojtab01a.pdf>

## *Addressing Stigma*

Although mental illnesses are surprisingly common affecting up to 28 percent of our nation, so is recovery. Studies show that many people with mental illnesses recover completely (SAMHSA, 2003). With treatments and supports available now more than ever, people with mental illnesses can lead active, productive lives and contribute to their communities.

Yet stigma continues to be a major barrier to seeking out care. Many people are still confused between facts and myths; they don't understand what mental illnesses are and continue to believe that there is something shameful about them. In addition to shame, minorities often feel the legacy of racism and discrimination, leading to the distrust of health and mental health professionals. Feelings of stigma, discrimination and mistrust of authorities preclude individuals in need from seeking out and receiving the help and treatments that can lead them to recovery.

Because the small numbers of minorities that do seek behavioral health care prefer seeking and receiving that care in primary care settings, it is in our best interest to nurture and further develop this entry point into treatment, and we must assure the presence of a sensitive workforce that is culturally and linguistically competent. As such, providers themselves will help to break down some of the barriers created by stigma, while providing needed care.

## *Access and Treatment*

While many people are given good mental health care and manage to recover, approximately 50% of those who need mental health treatments do not receive them (Kessler et al, 2002). In fact, the individuals that successfully reach care may find many treatments and services not to be available, or that the quality of care is inadequate and/or unsatisfactory.

Other systemic obstacles effecting behavioral health provisions in primary care settings include a fast work pace, high demand for services, restricted appointment access, lack of integrated behavioral health services, and financial disincentives in managed care contracts. Additionally, not all insurance plans pay providers for the additional time required to care for patients with mental disorders and many communities lack specialty mental health providers who can serve as consultants or provide referrals for patients whose needs cannot be solely met by their primary care providers (Strosahl, 2004).

Generally speaking, the rate of mental disorders among non institutionalized racial and ethnic minority populations is similar to that of Whites. The problem is that minority populations are at greater risk of remaining untreated, undiagnosed, or misdiagnosed. Unfortunately, practitioners do not always use best practices resulting in a poorer quality of care, with frequent incorrect or insufficient medication regimen.

Compounded by stigma and the greater propensity to express symptoms somatically, understanding help seeking behaviors of racial/ethnic minorities is an important factor in the overall health delivery equation. While Asian Americans report using general outpatient services for mental healthcare (Yeung et al, 2004), African Americans and Latinos are significantly more

likely to utilize emergency room services, and less likely to have a regular primary care physician (Collins, Hall and Neuhaus, 1999).

Richardson et al (2003) examined the quality of mental health care for African Americans (AAs), particularly in the provision of psychotherapy and pharmacotherapy. Findings revealed that African Americans who sought help from primary care physicians demonstrated no difference in scope of care when compared to Whites, but did indicate significant differences in their receipt treatment, particularly medications-- as they proved less likely to receive psychotropics. A secondary finding was that AA's were more likely to receive mental health counseling and psychotherapy from substance abuse clinics than from primary care and/or specialty mental health clinics, and that Whites were more likely to receive those services from specialty mental health clinics.

Snowden and Pingitore (2002) found that African Americans (AAs) with mental health complaints were more likely to visit primary care physicians than psychiatrists. But that as an unintended consequence, AAs who seek mental health care in primary care settings may inadvertently be receiving a lower quality of care. Although there is a growing body of data indicating some improvements, mental health specialists tend to diagnose more accurately and frequently than do non-specialists (Wells et al., 1989).

Drug and alcohol abuse and dependency is also largely underrecognized in primary care settings, and when correctly identified, is often unlikely to result in an appropriate treatment referral. Moreover, physicians fail to diagnose, in about half of their patients, the existence of a psychiatric morbidity and may not be fully aware of evidence-based practices and recent advances in the field of behavioral health (Higgins, 1994).

Research findings from the Mexican American Prevalence and Services Survey (MAPSS; Vega et al, 1998) provide corroborating evidence for dramatic disparities in mental health care for Mexican-Americans, the largest Latino subgroup. Data show that rates of psychiatric disorders in U.S. born Mexican-Americans were found to be almost identical to those among non-Hispanic Whites. However, only about 27 percent of those diagnosed with more than one DSM-III-R mental disorder received any kind of service. This contrasts with the White population figures that show 77 percent diagnosed individuals received services (Vega et al, 1999).

Similarly, Chung et al (2002) studied the degree to which primary care physicians recognized psychiatric distress among an ethnically diverse primary care sample comprised primarily of Asians and Hispanics. Higher patient acculturation level was the only factor significantly associated with overall diagnostic recognition. Being Asian or having low acculturation levels may put the patient at risk of not receiving an accurate diagnosis, and subsequent treatment intervention.

### *Suicide, an Unintended Consequence*

In the U.S., suicidal behavior constitutes a major public and mental health problem and is illustrative of the human consequence of when left untreated. Is a tragic response to multiple problems involving depression, substance abuse, and other factors like exposure to trauma and

violence, and loss of key social, family and community foundations. It is a single response to a multitude of problems.

Depression in adolescents presents an enormous risk factor for suicide in youth, particularly if coupled with inhibited emotional, cognitive and/or academic development, family problems, and/or the presence of chronic illness. Co-morbid conditions such as substance abuse and mental illness can be tragic contributors to mortality, with suicide perennially representing as one of the leading preventable causes of death in the United States. Young people aged 15-34 make up 64 percent of all suicides. It is the 8<sup>th</sup> leading cause of death overall, and the 5<sup>th</sup> leading cause of death for males—ahead of homicide. Nearly 60% of all suicides are committed with a firearm (CDC, 2004).

Suicide is the eighth leading cause of death for all U.S. men, as males use more lethal means and consequently are four times more likely to die from suicide than females (CDC, 2004). However, for American Indians and Alaska Natives (AIAN) aged 15-24, the prevalence rate of suicide is 2.4 times the national rate, or about 60 deaths per 100,000 individuals. For AIAN youth, ages 15-24, suicide is the second leading cause of death. Overall, violent deaths, unintentional injuries, homicide and suicide account for 75 percent of all mortality within 15-24 year old age range for AIAN (IHS, 2004)

Except for White men aged 74 and older, the overall rate for suicide for AIANs is 91 percent higher than for all races in the U.S. (10.6 per 100,000) (IHS, 2004). In addition, women report attempting suicide during their lifetime about three times as often as men (Krug et al. 2002).

Among African American youths, suicide, once uncommon, has also increased sharply in recent years. The suicide rate for these teens aged 15-19, more than doubled from 3.6 per 100,000 to 8.1. The latest statistics show that roughly 5.7 per 100,000 African American deaths are certified as suicide—a rate of 5 each day.

Suicide among Latinos is the third leading cause of death for youth aged 10-34 years, occurring predominately among males (CDC, 2004). However, the National Household Survey on Drug Abuse (SAMHSA, 2003) cites a disturbing trend among U.S. born Latina youth, aged 12-17 years. The survey found that Latinas are also at high risk of suicide—and describe them as youth who thought about or tried to kill themselves. These rates span across geographic regions and ethnic subgroups (Mexican, Puerto Rican, Central or South American and Cuban).

Compared to the suicide rate of Whites, the rates for Filipino (3.5), Chinese (8.3), and Japanese (9.1) Americans are substantially lower. However, Native Hawaiian adolescents have a higher risk of suicide than do other adolescents in Hawaii, and older Asian American women have the highest suicide rate of all women over age 65 in the United States.

This trend in suicidality for minorities will require a renewed and vitalized approach; one that involves the courage to switch gears. Reforms should promote prevention, early interventions, and involve families and whole communities.

### *Provider/Patient-Consumer Interactions*

Although most practitioners would assert that understanding and respecting the beliefs and values of their minority patients is essential when delivering quality care, they may also be, inadvertently, contributing to racial and ethnic disparities in health outcomes. Numerous examples of provider bias, stereotypes, beliefs or assumptions about behaviors, poor communication and interpersonal skills, and inexperience with a population have been cited (Commonwealth, 2002; IOM, 2001).

Mental health consumer responses and interactions with healthcare providers are particularly cogent when a perception of mistreatment, mistrust, disrespect, or general lack of understanding exists (Miranda et al, 2003). As a result, clinicians can view symptoms, diagnoses and treatments in ways that diverge from the views of the patients they treat.

In a report by the Commonwealth Fund (2004), Hispanics were twice as likely as Whites (33% vs. 16%) to find difficulties when communicating with their doctor, and cited problems such as not understanding the doctor, not feeling listened to by the doctor, and withholding questions from the doctor. Twenty-seven percent of Asian Americans and 23% African Americans experienced similar communication difficulties.

Ngo-Metzger et al (2004) found that Asian Americans were less likely than Whites to receive counseling from doctors about lifestyle or mental health issues. They were more likely to report that their doctors did not understand their background and values, and that they were not treated with a great deal of respect. Asian-American patients rated their overall interactions as unsatisfactory.

### *Role of Language in Patient/Provider Interaction*

Other than English, Spanish is the language spoken most often in the U.S. (11 million), with only half reporting speaking English very well (Census, 2003). Over 100 languages and dialects are spoken in Asian American and Pacific Islander (AAPI) households and about 35% live in households where there is Limited English Proficiency (LEP). Some of the AAPI population subgroups have higher rates of LEP: 65% Hmong, 56% Cambodian, 52% Laotian, 44% Vietnamese, 41% Korean, and 40% Chinese. The ability to speak English well at home is displayed below in Table 4.

**Table 4: Population  $\geq$ 5 Years by Language Spoken at Home and Ability to Speak English, 2000**

<b>Languages Spoken at Home &amp; Ability to Speak English language</b>	<b>Does Not Speak English Well or Not at All, %</b>
Speak Languages Other Than English	17.0
Spanish	28.3
Other Indo-European	13.0
Asian and Pacific Islander Languages	22.5
Other Languages	10.1

Source: <http://factfinder.census.gov>

The ability to communicate and be understood is essential for receiving good mental health care. According to the 2000 census, over 4 million people were living in linguistically isolated households; where no household member age 14 years or over reports speaking English well. Table 5 demonstrates the estimated number of linguistically isolated households in 2003.

**Table 5: Estimated Total Number of Linguistically Isolated Households**

<b>Language</b>	<b>Number of LI Households</b>	<b>%</b>
Estimated Total	4,393,921	100
Spanish	2,671,805	60.8
Chinese	291,801	6.6
Korean	139,053	3.2
Vietnamese	137,019	3.1
Russian	136,313	3.1
Other LI	1,017,930	23.2

Source: Joint Statistical meeting, August 2003  
 Presentation by P.G. McGovern and D.H. Griffin.  
<http://www.census.gov/acs/www/Downloads/ACS/asamcgovern.pdf>

Many Latinos have Limited English Proficiency (LEP) and although Hispanics-Latinos now account for over 13% of the total U.S. population, there continues to be a dearth of qualified Hispanic-Spanish speaking bilingual and bicultural health and mental health care professionals in the United States. In fact, Latinos comprised only 3.3% of physicians, 4% of psychologists, 7% of social workers, and 2.4% of nurses in 1999 (Bureau of Labor Statistics, 2003; Bureau of the Census, 2003; American Medical Association, 2004).

Because of the importance of interpersonal communications between the patient-consumer and provider of mental health services, it is essential to include the role and strength of cultural and linguistic competencies in this process. Cultural and linguistic competence can be conceptualized in terms of organizational, structural, and clinical (interpersonal) barriers to care. The Office of Minority Health (2001) defines cultural competence as the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter. At the patient-provider level, it may be defined as the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences.

Given the importance of language to mental health service provision and adherence, the need for appropriate interventions is clear. Effective programs in diverse communities must be tailored to individual and community needs, and take into consideration factors concerning language, culture, race and ethnicity, which also play a significant role in determining health and mental health outcomes.

## *Workforce Challenges: Present and Future*

Over twenty-five percent of the U.S. population consists of racial and ethnic minorities, yet, these populations are poorly represented among physicians and other mental health providers. African American, Latino and American Indians make up for less than 6 percent of physicians. Although aggregate data show that Asians are overrepresented in the medical school population, figures do not disclose a complete picture. For example, data do not reflect the shortages that exist for several underrepresented AAPI groups like Laotians, Cambodians and Samoans.

Research shows that patients prefer practitioners who share their race/ethnic background in the patient/provider encounter (Garcia et al, 2003). And although there are few studies examining the impact of patient/provider race concordance on service utilization and outcomes, there is reasonable evidence of higher patient satisfaction among adult primary care patients. Further, patients seeing physicians of the same cultural background might feel more comfortable when communicating mental health issues (Commonwealth Fund, 2004; Cooper, 2003).

Table 6 provides the total number and percentage of physicians in the U.S. by Race and Ethnicity for 2003.

**Table 6: Total Physicians by Race and Ethnicity, 2003**

<b>Race and Ethnicity, Physician</b>	<b>Number</b>	<b>Percentage</b>
White, Non Hispanic	432,054	51.0
African American/Black	20,876	2.4
Hispanic	28,536	3.3
Asian/Pacific Islander	73,702	8.6
American Indian/Alaska Native	503	0.05
Other	20,161	2.4
Unknown	277,355	33.0

Source: AMA, 2004

Equally interesting is that minority physicians have a greater propensity to provide care for minority patients, in addition to work in medically underserved areas (Proser & Cox, 2004; United States Department of Health and Human Services, 2000). However, because of the low representation of minority practitioners, cultural and linguistic concordance between patient and provider is not always possible.

The racial and ethnic composition of the psychiatric workforce is largely White. Although Asian psychiatrists are overrepresented in the psychiatry workforce as compared with the general population, this may not reflect the enormous cultural and linguistic diversity among Asian and Pacific Islander populations (AAPIs), with about 43 different ethnic subgroups. Furthermore, the numbers of African-American psychiatrists and Hispanic psychiatrists continue to be grossly underrepresented. A recent report on minorities in health professions stresses the critical need to recruit minority providers who are likely to serve minority communities (The Sullivan Commission, 2004).

The expectation that health professional and practitioner training emphases and practices may change is also based on documented gaps in underserved populations and societal trends. For example, there is a growing need for psychologists and other mental health professionals to provide services to older Americans (Gatz and Finkel, 1996). Although predoctoral and postdoctoral training opportunities are increasing, more expansion in this area is needed (Hinrichsen, et al., 2000).

Other need areas in behavioral health include the provision of treatment to individuals with serious mental illness, individuals residing in rural areas, children with mental health problems, underrepresented minorities, and individuals in primary care settings (Levant et al., 2001; McDaniel, et al., 2002; Mulder et al., 1999). Moreover, the body of knowledge on the etiology and treatment of mental health problems is rapidly growing, along with the involvement of psychologists in additional service activities (e.g., prescription monitoring). Attention to these needs through changes in training will continue during the next decade to address. The challenge will be in the psychiatry and psychology curriculum development, with the need to address the growing body of scientific knowledge, but also that of special population categories like racial and ethnic minorities, children, geriatrics and rural (SAMHSA, 2004).

The lack of representation among racial and ethnic minority mental health providers will become an obstacle in the near future. In the next 10 years, multicultural issues will have an impact on all aspects of counseling. With minority practitioners being underrepresented, targeted efforts to increase diversity, workforce recruitment, multicultural training and multicultural community outreach will be essential.

## Summary

This issue brief provides an overview of the provision of mental health interventions in primary care settings for racial and ethnic minority populations, highlighting studies that discuss those populations that have received behavioral health treatment; including access, utilization and outcomes of those treatments. It discusses strengths and challenges from the individual and systemic perspectives, including the need for mental health specialists and primary care providers to work collaboratively and cohesively. This brief discusses the poor utilization rate of mental health services by minority populations and identifies the point of entry to mental health services by those few that do receive care. Given that primary care settings are the point of entry to services by minority populations, it is imperative that some type of systems change be implemented. For example, mental health services might be co-located in primary care settings and that these receive the appropriate tools to provide culturally and linguistically sensitive care. There is an urgent need to also train more minority, and bicultural/bilingual primary care and mental health providers. Major findings include:

- Minority populations are often over represented in our nation's most vulnerable populations, such as the homeless, the incarcerated, the uninsured and the poor.
- Barriers such as stigma, poverty and linguistic isolation are experienced more often by racial and ethnic minorities.
- Racial and ethnic minorities underutilize mental health services; but when they do receive care, it is from primary care settings more often.
- For minorities seeking and receiving mental health treatments, the appropriateness and quality of those treatments remain in question, regardless of location or point of entry into the system.
- The need to strengthen the capacity of primary care setting to provide appropriate mental health services.
- Continued unmet needs and the provision of substandard mental health services to minority populations can only lead to a negative impact the well being of our nation. This negative impact has both economic and social consequences.

The growing recognition of the role of primary care settings for the delivery of mental health services for minorities is noteworthy, particularly with a system integration of health with behavioral health specialists. But more needs to be done to establish an understanding that physical and behavioral health are treated equally.

It is clear that providing for behavioral health needs at primary care settings will be a positive move in reaching racial and ethnic minority populations. With primary care settings serving as a main portal to minorities seeking health and behavioral health interventions, it is a natural and obvious fit.

Yet, significant challenges remain. A systems change will require that we embrace a change in our thinking; an ongoing commitment and steadfastness. Minority and bilingual providers need to be trained, recruited into the workforce and retained. Cultural nuances, protective and risk factors, and biases (stigma) must be understood, respected and also taken into consideration when developing new models for services, in addition to developing new approaches to outreach, education and communication. Finally, sustainable models of integrative services have yet to be studied and evaluated. Support for this process is needed.

## **Recommendations**

The following section highlights recommendations, including suggestions for immediate action.

**Recommendation 1:** The Office of Minority Health, Office of Public Health and Science/OS, in its leadership role with the HHS Disparities Council, should assure that mental health and behavioral health in general become a primary focus of attention, and will assure that mental health becomes a public health issue. Specifically, the OMH should:

- Designate behavioral health as a health disparity category. This will bring a higher level of attention to this topic.
- Coordinate minority mental health agenda throughout HHS with development of a task force. Assure for diversity and experience on task force.
- Ensure accountability and participation of Operating Divisions to develop a coordinated research and service agenda for underserved minority populations. Mandate collaboration for developing a working agenda-- programmatically and fiscally.
- Continue to detail the needs. All involved need to understand how the nation is affected by mental health policies, programs and funding strategies, the adequacy of existing programs and additional needs.

**Immediate Step:** Designate mental health as a health disparity category. Not only will it validate that mental health is a part of health, but also allow for collaboration and resources.

**Recommendation 2:** Office of Minority Health, Office of Public Health and Science/OS, will take the lead in establishing effective policies that create and build a competent minority healthcare and mental health workforce. The OMH should take the lead to:

- Implement recommendations made by the Sullivan Commission Report: Missing Persons: Minorities in the Health Professions (2004). Ensure for the development of a diverse, professional and culturally/linguistically competent mental health workforce.
- Provide incentives to mental health professionals, as well as to physicians who serve in federally designated high priority areas. Expand this area.
- Ensure for a diverse minority representation in HHS workforce. Renew commitment to hiring and retaining a competent and diverse workforce. Make thoughtful, strategic and concerted effort to hire underrepresented minorities; provide incentives (i.e. loan repayment and moving costs). Provide hiring opportunities at all levels: entry and leadership.

**Immediate Step:** Establish an intra-agency task force that will establish measurable goals, strategies and outcomes.

**Recommendation 3:** Improve measurably, the knowledge base of behavioral health treatments for racial and ethnic minority consumers. There is a growing knowledge about the etiology and typology of mental health and substance abuse disorders, and their comorbidities, along with improvements of effective interventions for minority populations. However, less is known about evidence based interventions for minority populations. Although the body of literature on mental health conditions and treatments in minorities is small---it does exist. We should encourage future translational research related to ethnic minorities in the targeted communities.

Therefore, in order to create improvements over status quo, the OMH should take the lead to:

- Increase number of studies on behavioral health conditions of minority populations, assuring that funding supports large sample sizes, geographic diversity, linguistic diversity, etc.
- Continue to support the national collection of racial and ethnic minority population data; including those who constitute smaller population samples (i.e. Hmong) and those designated “hard-to-reach”.
- Increase funding to minority researchers who target mental health and minorities.
- Reward innovative, community based, minority focused research and evaluation by designating targeted funding priorities.

**Immediate Step:** OMH will work with HHS Operating Divisions and Offices with grant making authority in the creation of RFAs and procurements that are targeted to mental health for minority populations.

**Recommendation 4:** Increase the number of co-located mental health and primary health care service clinics targeted in predominantly low-income and minority communities. Racial and ethnic minorities seek behavioral health care more often from primary care providers. However, primary care providers are less prepared to accurately recognize and diagnose for behavior health problems. The OMH should take the lead to:

- Mandate HHS-wide collaboration for integrating mental health and primary health care services.
- Tackle the administrative and funding barriers that prohibit integration of services. Promote and support individuals, systems and exemplary models.
- Support the development of a blue print for integration of mental health and health services, leading to an overall ‘systems of care’ approach.
- Prioritize the need for interdisciplinary work between primary health care providers and mental health researchers and providers.
- Provide incentives for medical schools to give greater priority to mental health training.
- Support the development and evaluation of demonstration projects for mental health in primary care settings for minority populations.
- Promote and support innovation within and outside of government.

**Immediate Step:** Support the development of a demonstration project through the cooperative agreement mechanism, for mental health in primary care settings for minority populations. Add an evaluation component so as to capture core criteria across the grant sites. For example, develop a cooperative agreement demonstration program that will train primary care physicians to accurately detect, identify and treat mental health problems for racial and ethnic minority populations, and/or refer to appropriate mental health professionals when needed.

**Recommendation 5:** Target culturally sensitive and linguistically competent mechanisms to combat stigma. The Surgeon General (DHHS, 1999) asserted that low funding and limited attention to the mental health agenda was in itself due to stigma. Public health messaging is powerful, especially when coupled with policies. Much needs to be done to debunk the mythology surrounding mental health and illness, especially with regard to the underpinnings, treatments and potential for recovery.

This is particularly cogent for racial and ethnic minorities who grossly underutilize needed mental health services, often due to stigma. OMH will provide leadership to:

- Establish and coordinate HHS-wide mental health anti-stigma campaign, with special emphasis on eliminating stigma within racial and ethnic minority communities.
- Use the OMH Standards on CLAS as a framework to develop
- Coordinate and support the development of culturally sensitive and linguistically competent communications with the intent to change attitudes about mental health among minority populations, as well as increase knowledge about mental health about access and to access mental health services.
- Target vulnerable racial and ethnic minority communities in urban, suburban and rural areas.
- Partner with consumer and professional organizations.
- Create public and private partnerships in the development of these targeted messages, using well known media mechanisms.

**Immediate Step:** Solicit a contract focusing on the development of culturally sensitive and linguistic specific messages that will increase community-level knowledge about mental health, and improve access to treatments for minority populations--ultimately leading to the reduction of stigma. Method: using language specific and culturally sensitive strategies, through various media strategies.

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