

# CULTURAL DIFFERENCES IN ACCESS TO CARE

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■ **Abstract** As high-profile reviews have appeared and international interest has grown, sophisticated studies of the U.S. population continue to document racial and ethnic disparities in initiation of mental health care and in continuity of care. Many explanations focus on cultural factors: trust and treatment receptiveness, stigma, culturally distinctive beliefs about mental illness and mental health, culturally sanctioned ways of expressing mental health-related suffering and coping styles, and client preferences for alternative interventions and treatment-seeking pathways, as well as unresponsive programs and providers. The research itself has become more rigorous and informative, but it continues to lack theoretical focus and does not yet yield cumulative findings. Too few studies have addressed community and regional differences or differences between mental health treatment programs and systems, or considered mental health-related policies that are very likely linked to disparities. Theoretically well-formulated studies on representative samples can provide a comprehensive explanation of access disparities in cultural and culture-related terms that inform a broad-based plan of remedial intervention.

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## CULTURAL DIFFERENCES IN ACCESS TO CARE

In the United States and worldwide, relatively few people who need mental health treatment receive it. Access to mental health care—defined as the “timely use of personal health services to achieve the best possible health outcomes” (Millman 1993)—is often a challenge to realize. Sometimes, as for parents of the 12,700 children placed in child welfare or juvenile justice systems for the express purpose of receiving mental health care (*New York Times* 2003), gaining access to treatment is a nightmare.

Although few people in need of mental health treatment receive it, ethnic minority persons are among those least likely to receive services appropriate to their needs. Many of the factors believed to account for this disparity—mental health-related cognitive schema, attitudes, and preferences, among others—are properly termed “cultural.” Clinical psychology is well represented among disciplines and professions that have made progress in learning a great deal about the segments of people most likely to use services; however, much more remains to be learned.

Attention to problems of culture and access to mental health care is widespread. A 14-country, cross-national comparison of mental health service use appeared recently, highlighting differences in access between developed and developing countries (Demyttenaere et al. 2004). How mental health systems are organized and financed appears to interact with cultural factors to produce wide-ranging variation in rates of access. An international consortium on mental health policy and services was established to generate mental health policies guidelines that consider demographic, economic, and cultural factors in developing countries’ current mental health service systems (Gulbinat et al. 2004).

In another key enlargement of focus, concern about culture and access has been introduced into the growing body of knowledge on mental illness prevention (Muñoz et al. 1996). A workgroup sponsored by the National Institute of

Mental Health and assigned to develop recommendations to improve access to preventative and treatment options for depression (Hollon et al. 2002) suggested increasing the involvement of minority researchers and developing user-friendly and nontraditional delivery methods to increase access to evidence-based interventions. A similar workgroup used social marketing research to consider strategies for increasing ethnic minority populations' access to services, particularly among persons with affective disorders (Bruce et al. 2002).

Access alone does not insure better mental health, because access does not guarantee that mental health treatment, even if received, will be high quality. Researchers are paying much-deserved attention to quality, including disparities in quality of care delivered to groups differing in ethnicity and culture [U.S. Department of Health and Human Services (DHHS) 2001]. However, if access alone is not sufficient, it is necessary for treatment-conferred improvement—both initial entry into treatment and care that is continuous enough to permit treatment to take effect. Treatment timeliness and intensity are linked to improvement (Brekke et al. 1997, Fortney et al. 2003).

This chapter clarifies issues and reviews evidence on culture and ethnicity and their relationship to mental health care access. We emphasize literature published after the extent of disparities was brought into the national spotlight by the seminal Surgeon General's Report (U.S. DHHS 2001), as well as controlled studies and studies that use community samples (preferably representative community samples). We include these kinds of studies because rigorous and realistic sampling is crucial for accurately generalizing to ethnic and cultural populations of concern (Sue 1999).

Our approach reflects a wider health services research perspective, which encompasses local organizations and programs as well as the overall organization and financing of the delivery system itself. We believe a wider health services research perspective to be a fruitful framework for considering key concerns bearing on health care and mental health care access. By examining minority access to mental health treatment in a wider context, we discover a general framework for considering problems. For example, among the Institute of Medicine's ten rules for closing the "quality chasm" for improving health care are requirements for "care based on continuous healing relationships," "shared knowledge based on the free-flow of information," and "customization based on patient needs and values" (Institute of Medicine 2001). According to the Institute of Medicine, high-quality health care—including mental health care—demands that we address continuity problems like the "drop-out problem," as well as difficulties in sharing knowledge through open communication channels and failures to customize treatment to account for sociocultural differences.

Health services researchers recognize that mental health treatment occurs in a relationship between a therapist or other care provider and a person in need, and that the person in need seeks or is compelled to enter treatment. The help-seeking person interprets his or her troubling experiences through a culturally influenced prism and often copes by consulting others, sometimes including mental health professionals.

Beyond the characteristics of the help-seeking person and his or her relationship with a care provider, there is a mental health treatment system composed of personnel who practice in health care settings, as well as organizations and systems (linked by custom and contract) that are controlled through regulation and the provision of incentives, and that change over time. From our wider perspective, clinical psychologists and other trained practitioners are viewed as treating clients whose interventions are financed from public or private sources. These providers practice alone or in groups, programs, or networks—all governed by an enveloping, ever-changing network of state, local, and federal policies. However confusing and seemingly arbitrary—and however the term may have been abused—the mental health treatment system is a system, and, in ways we are only beginning to understand, characteristics of that system affect ethnic and cultural disparities.

## CULTURE AND HELP SEEKING: EXPLANATORY FRAMEWORKS AND THEORIES

For many years, cross-cultural theorists and researchers have recognized that cultures vary in how their members conceive of problems we term “mental illness,” and in how, with whom, and when distressed persons appropriately seek assistance. In influential early work, Kleinman (1980) proposed that illness-related beliefs formed culturally influenced “explanatory models,” and that help-seeking tendencies logically followed (e.g., a person’s deep sense of discouragement is interpreted as a sign of spiritual crisis, in response to which he or she prays and consults a respected religious figure). Explanatory models can now be assessed using structured procedures (Lloyd et al. 1998).

Theorists have proposed several help-seeking models to explain access to health and mental health care as a kind of help-seeking behavior—although we understand that help seeking and access are not one and the same, and that the help-seeking person may or may not have access. From a wider perspective, help seeking can be interpreted as a form of coping with distress. Some theorists have argued that help seeking provides a unique opportunity to consider cultural influences on mental health (Rogler & Cortes 1993). Social psychologists seeking to understand African American community life have extensively studied African American mental health–related help seeking as a part of supportive community-based processes (Neighbors & Jackson 1996).

Best known among general help-seeking models is that of Anderson (1995), which categorizes explanatory variables as predisposing factors, enabling factors, and need. The Anderson model is not a theory of help seeking, but instead is a useful framework for categorizing familiar and empirically established explanatory variables. It can serve as a preliminary guide toward more fine-grained theories suitable to particular circumstances of application.

Health services researchers often assess help seeking as an event that did or did not occur over a specified interval, and that, if it occurred, has a certain frequency

of occurrence. This characterization captures a distinction between initial entry on the one hand, and continuity, premature termination, or treatment intensity on the other. Health and mental health services researchers reflect this distinction methodologically in two-part models, where part one addresses the probability of any treatment having taken place and part two addresses—contingent on any treatment—use intensity.

Although useful, these event-oriented approaches fail to address many of the complexities describing how people receive care. Potentially fruitful, but not yet employed for studying ethnic and cultural differences, is an episode-oriented approach to studying access, wherein analytic units are defined by clinically meaningful segments of time.

Another limitation of the event-oriented approach is its static character. Help seeking is a process wherein distressed persons sometimes consult several potential sources of assistance concurrently as well as sequentially, in socially influenced steps with feedback loops. A comprehensive “network-episode”-like approach (Pescosolida 1992) may give a better account of cultural influences in help seeking than does the current one.

## BRINGING ETHNIC AND CULTURAL ACCESS TO MENTAL HEALTH TO THE FOREFRONT: LANDMARK REVIEWS

Several reviews issued in the past few years document racial, cultural, and ethnic differences in mental health care access—either discretely or as part of disparities in general health care systems.

Recently, the President’s New Freedom Commission on Mental Health (Hogan et al. 2003) issued a report whose conclusions underscore racial, cultural, and ethnic problems in access. The Commission concluded that “barriers still remain in access, quality, and outcomes for minorities.” Like the Surgeon General, the New Freedom Commission further concluded that minorities suffer a “higher burden of disability” because of access limitations.

In its report, “Unequal Treatment: Confronting Racial and Ethnic Differences in Health Care,” the Institute of Medicine emphasized that disparities went beyond differences in health status and access, which might be explained by clinical care appropriateness and patient preferences (Smedley et al. 2003). The report states, “Evidence of racial and ethnic disparities is, with few exceptions, remarkably consistent across a range of illnesses and health care services. The majority of studies find that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other health care access-related factors” (p. 5).

These documents have brought to the forefront of the national policy agenda the issue of improving ethnic minority well-being through better access to mental health and health care. Many federal agencies that are responsible for health care and health care services have responded to this issue, including the National

Institutes of Health, which developed an interagency research agenda on health disparities and, in 2000, founded The National Center on Minority Health and Health Disparities.

The most comprehensive consideration of ethnic and cultural disparities in mental health was introduced at the Annual Convention of the American Psychological Association Convention in 2001, when the Surgeon General released “Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General” (U.S. DHHS 2001). Evidence reviewed there clearly indicated disparities in mental health care for African Americans, Latinos, Asian Americans, and Native Americans. The report documented that minority persons are less likely than others to enter mental health treatment and that, among the relative few who do receive mental health services, a significant proportion fail to receive continuous care. Other access problems reflect too great a reliance on treatment programs, including, for some groups, greater-than-expected numbers of minority persons who seek mental health assistance in emergency rooms, inpatient settings, and through child welfare placement. The report states, “Minorities have less access to, and availability of, mental health services; minorities are less likely to receive needed mental health services; minorities in treatment often receive a poorer quality of mental health care” (U.S. DHHS 2001, Executive Summary, p. 12).

## RECENT SURVEY-BASED FINDINGS ON ACCESS

Since the issuance of the Surgeon General’s Supplement on Culture, Race, and Ethnicity, several researchers have published national estimates of disparities in specialty-sector mental health service use. Their data have come from several large, epidemiologic and health policy-related surveys that addressed mental health and help seeking, including the National Comorbidity Survey (NCS), the Robert Wood Johnson Healthcare for Communities Survey, the National Medical Expenditure Survey (NMES), the National Health Interview Survey Disability (NHIS-D) Supplement, and the National Survey of American Families. Others have published results from regional surveys focusing on mental health problems and help seeking in particular ethnic minority populations. The results provide a more detailed picture of disparities in access than had appeared previously, and to a lesser extent, address differences in continuity.

Reanalyzing data from the NCS, Alegria and colleagues (2002) confirmed that African Americans and Latinos were less likely than were whites to receive mental health treatment, and they identified social position and environmental moderators of disparities. They reported that Latino-white disparities were significant among the poor, and that African American–white disparities were pronounced among persons living in the South and the West, and among other-than-poor persons. The NCS was administered only in English and may underestimate Latino-white disparities.

That African American–white disparities were found to be lowest among the poor is consistent with findings from secondary analyses of the NMES, which show that disparities were lowest when treatment was financed from public sources that pay treatment costs for the poor (Snowden & Thomas 2000). It is also consistent with findings from New York State, which show that disparities were lowest among residents of poor neighborhoods who sought mental health treatment (Chow et al. 2003).

Wells and colleagues (2001) reanalyzed data from the Healthcare for Communities Survey to examine whether African Americans and Latinos with mental health, alcohol, or substance abuse problems were less likely than whites to receive primary or specialty mental health or substance abuse care. They found that among persons identified as having a need for treatment, whites were about 1.5 times more likely than African Americans or Latinos to receive it. Lasser and colleagues (2002) reanalyzed the NMES in order to provide another comprehensive national estimate of disparities, and found that African Americans and Latinos received about half as much outpatient mental health care as received by whites.

Vega and colleagues (1999) provided the best recent data on mental health service use among Mexican Americans. Only about 8.8% of the Fresno County, California residents who met criteria for a DSM-III-R disorder received specialty mental health treatment. About 15% of Fresno's Mexican American residents who met diagnostic criteria and indicated functional impairment received any specialty mental health care (Peifer et al. 2000).

Reporting on the Los Angeles–based Chinese American Psychiatric Epidemiological Study, Kung (2003) indicated that only about 15% of respondents who met diagnostic criteria for mental illness received mental health specialty care. This treatment rate is lower than nationally observed rates for African American, Latino, and white persons with documented need (Wells et al. 2001), although regional and national comparisons must be interpreted with great caution.

Other investigators provided welcome national estimates of access disparities for children. Witt and colleagues (2003) turned to the NHIS-D, a supplement to the NHIS that focuses on children 6–17 years of age with physical disabilities. The questionnaire incorporated a measure of psychosocial adjustment, the Personal Adjustment and Role Skills Scale, which was included in a multivariate analysis to control for whether there was any need for mental health treatment. The investigators found that African American and other nonwhite children were less likely than whites to receive mental health care. They also reported that African American, Latino, and other children were less likely to have coordinated care.

Reanalyzing data from three national surveys, Kataoka and colleagues (2002) examined disparities in specialty care for children ages 6–17. Uncontrolled results confirmed the presence of African American–white and Latino–white disparities, which persisted in controlled analysis more for Latinos than for African Americans. Greater enrollment in public sector finance and representation among children with greater need appeared to mediate disparities. However, among children ages 4–17 assessed in an epidemiologic survey in Puerto Rico, Canino et al. (2004)

reported that of the 25.7% meeting DSM-III-R criteria, 25.7% without functional impairment received any treatment and 49.6% with functional impairment received treatment.

Limited evidence suggests that disparities in access to care persist into older adulthood (Mills & Edwards 2002). In Brooklyn, elderly African Americans—especially Caribbeans—had significantly more psychotic symptoms than did elderly whites, but were less likely to have received mental health treatment (Cohen et al. 2004). Disparities in utilization among Latinos have also been documented, although evidence suggests a need for further examination of variance in use rates among subgroups of older Latino adults (Bastida & Gonzalez 1995).

The data continue to demonstrate minority–white disparities, and suggest important regional, socioeconomic, sector, and finance-related disparity mediators. In order to target the groups with the greatest unmet need and to further develop hypotheses to explain disparities, more information is needed on subpopulations comprising the broad ethnic categories typically employed. For instance, estimates of Native American populations' help seeking have been especially rare, hampered perhaps by the existence of more than 500 recognized tribes served in part by separate health and mental health systems, including the Indian Health Services and tribally negotiated health care and mental health arrangements (Gone 2004, Johnson & Cameron 2001).

## RECENT FINDINGS ON PREMATURE TERMINATION AND CONTINUITY

Researchers have repeatedly demonstrated that disrupted care continues to plague minority clients after barriers to initial access have been surmounted. Studies of the minority dropout problems include research on African Americans (e.g., Armistead et al. 2004, Murry et al. 2004), Latinos (e.g., Gallagher-Thompson et al. 2003), older adults (e.g., Arean et al. 2003, Lau & Gallagher-Thompson 2002, Levkoff & Sanchez 2003), youths (McCabe 2002), families (e.g., Gross et al. 2001, Kumpfer et al. 2002, McCurdy et al. 2003), and clinical psychopharmacology clients (e.g., Miskimen et al. 2003).

Several investigators evaluated social and cultural variables in explaining interrupted care and lesser treatment intensity among minority clients in mental health treatment. Acknowledging vulnerability to premature termination, they devised strategies to maintain minority participation in treatment intervention studies.

One study reported that methods that take account of consumer preferences and provide consumers with control of the process to the greatest possible extent were successful in retaining ethnic minority older adults, decreasing the likelihood of their dropping out (Arean et al. 2003). Armistead and colleagues (2004) achieved high retention rates with African American study participants, using a broad-spectrum approach to promote involvement: eliciting community involvement in study design, attempting to remove identified barriers to participation (e.g., child

care and transportation), and emphasizing positive interpersonal skills among study personnel. These authors noted that participants appreciated interacting with the same staff throughout a longitudinal study, and as a result were more likely to continue in the protocol (see Conduct Problems Prevention Research Group 2002).

Elsewhere, study participants themselves identified features they found encouraging and helpful in continuing their participation. These included a convenient study location, a match between participants' and programs' goals (Levkoff & Sanchez 2003), and a lack of schedule constraints (Gross et al. 2001). Miranda and colleagues (2003) noted improvement in retention rates of low-income English- and Spanish-speaking Latinos with depression when supplemental case management was added to their treatment protocol.

Ethnic matching of client and practitioner has long been considered important for keeping clients in treatment. However, from meta-analysis, reviewers concluded that ethnic matching was not an important predictor of premature termination and treatment intensity (Maramba & Hall 2002).

Social and cultural explanations for ethnic variation in premature termination and continuity have not been sufficiently evaluated. One study suggests that underlying cultural dispositions might play an important role. In a six-site, cross-national study of depression treatment and dropout rates in primary care settings (Bech et al. 2003), patients in two highly individualistic nations—Australia and the United States—had more than double the client dropout rate than that of patients in the four less individualistic nations (Russian Federation, Israel, Spain, and Brazil). The higher dropout rates occurred in spite of greater access to treatment and medications in the individualistic nations, features that are associated with lower rates of dropout.

As we discuss below, health services researchers' expectations about why minority persons reluctantly participate in mental health treatment have proven surprisingly difficult to confirm empirically. In addition, to better understand premature termination and continuity, more attention should be paid to how treatment relationships develop. The therapeutic alliance (Martin et al. 2000) and the role of ethnic and cultural differences in its successful formation seems a promising area for further inquiry.

## CHILDREN AND YOUTHS: BEYOND THE SPECIALTY MENTAL HEALTH SECTOR

The role of sectors other than specialty mental health is especially important to consider for addressing children and adolescent mental health care access. Children and adolescents usually enter treatment when troubling behavior comes to the attention of their caretakers or others, including school personnel and the police, and they are referred for treatment accordingly (Cauce et al. 2002).

School-based services provide the bulk of mental health care to children and adolescents, and school-based health centers have seen an increase in the

number of mental health visits made by hard-to-reach ethnic minority adolescents. Over a five-year period from 1988 to 1993, inner-city, low-income Latino and African American adolescents were more than 20 times more likely to seek mental health services at the school center in comparison with a community health center (Juszczak et al. 2003). Likewise, in a rural sample of children and adolescents, African Americans were as likely as whites to receive school-based care, but were less likely to receive care in the specialty mental health care sector (Angold et al. 2002). Angold and colleagues found that school-based clinics were used by children despite identified barriers to care.

Studying Native American youths in a tribal-based and urban-based sample, Stiffman et al. (2003) reported that youths needing mental health or substance abuse assistance used both specialty mental health providers and traditional healers relatively infrequently. Native American youths in the sample were far more likely to seek assistance from others who were not mental health specialists, such as teachers and other concerned adults.

Almost 42% of children placed in foster care suffer from a DSM-IV disorder (Garland et al. 2001), and as many as two thirds of children placed in foster care have been treated by a mental health specialist after being referred by child welfare personnel (Farmer et al. 2001). Children involved with social services but not placed in foster care have equally high specialty treatment rates (Farmer et al. 2001).

Youths also receive services through primary health care settings and the juvenile justice system (Cauce et al. 2002). Along with nonprimary care clinics and the child welfare system, these services share the distinction of not being designed to handle mental health issues in the proportion to which they are used (Hoagwood & Jensen 1997). Ethnic and racial minority children and adolescents are referred for mental health treatment from involuntary sources (e.g., child welfare and juvenile justice) more often than are white youths (Yeh et al. 2002).

## **MEDIATORS: CULTURALLY SANCTIONED BELIEFS AND PRACTICES, KNOWLEDGE, COPING, AND SYMPTOM EXPRESSION**

The Surgeon General's report (U.S. DHHS 2001) discussed several factors that might help to explain racial and ethnic disparities in access. These include differences in treatment-seeking pathways that favor nonspecialty sources of assistance, trust and treatment receptiveness, stigma, and culturally distinctive styles of expressing mental-health-related suffering.

### **Primary Care and the General Medical Sector**

Because of what is thought to be a greater tendency to express symptoms as somatic complaints, African American, Latino, and Asian American help seekers are

believed more likely to seek help from the general medical sector than from mental health specialists. For everyone with mental health concerns, more assistance for mental health problems takes place in the general medical sector than in the specialty sector, and national estimates for adults suggest there are few differences between African Americans, Latinos, and whites in the use of primary care or other sources in the general medical sector (Alegria et al. 2002, Wells et al. 2001). However, conflicting data exist on African Americans' use of the primary care and general medical sectors. One study reported that African Americans made fewer visits for mental health concerns to primary care settings (Lasser et al. 2002). Conversely, representative national data showed that—among users of the health care system, including minority persons who have overcome barriers to entry—African Americans with mental health concerns did appear to be especially likely to visit primary care settings (Snowden & Pingitore 2002).

## Alternative Treatments

Another culture-related hypothesis is that ethnic/racial minority persons use conventional care less because they prefer alternative (non-Western) medicinal substances, practices, and practitioners. Again, this claim must be evaluated in light of the fact that complementary and alternative medicine is widely used in the general population. From the NHIS data, Barnes and colleagues (2004) reported that 62% of adults use complementary practices for health purposes, including megavitamins, Tai Chi, acupuncture, and chiropractic care. African American adults (71.3%) and Asian American adults (61.7%) were high users of complementary and alternative medicine. Latino clients were higher complementary users than were non-Latinos when prayer for health conditions was considered an alternative practice. Racial and ethnic minorities used all types of complementary services to a greater degree than did whites, except in the use of manipulative and body-based therapies, in which case the reverse pattern was noted.

Another nationally representative sample assessed use of all medications, including over-the-counter drugs, vitamins and minerals, and herbal preparations/natural supplements (Kaufman et al. 2002). The overall rate of medication use varied across race/ethnicity groups, with whites and American Indians reporting the highest use (84%) and Asian/Pacific Islanders using the least (57%). African Americans and Latinos had comparable use rates (about 75%).

On the other hand, an earlier study by Mackenzie et al. (2003), from the National Comparative Survey of Minority Health Care, reported no across-group ethnic or racial group variation in the percentage of persons using one or more complementary therapies. Similarly, with an older adult, rural Southern convenience sample, Cuellar and colleagues (2003) found few differences between the African American and white populations. No racial/ethnic differences were described by Cherniack and colleagues (2001) in their study of older urban adults.

Whether minority persons are considered to use alternative therapies more than whites appears, in part, to depend on the range of practices counted as alternative.

In any event, it is unlikely that alternative therapy use explains disparities in mental health treatment seeking because alternative therapies are used as complements (in conjunction with), rather than as substitutes, for conventional care (Druss & Rosenheck 1999). On the other hand, researchers have not yet directly evaluated complementarity-substitution of nontraditional healing for specialty mental health care in culturally diverse populations, so the possibility of greater substitution cannot be ruled out entirely as an explanation for lower levels of minority specialty mental health care.

## Trust and Treatment Receptiveness

Among the culturally relevant barriers to treatment, cultural mistrust among African Americans has been touted as an explanatory variable in predicting help seeking. In an empirical test, African American men with mild symptoms of paranoia were hypothesized to be wary of outpatient treatment and, because they lacked regular outpatient care, to be hospitalized relatively frequently. However, they were found *less* likely than others to be hospitalized, apparently avoiding all contact with the mental health system (Whaley 2004).

On the other hand, there is evidence that if generalized mistrust occurs, it does not translate into a generalized lack of receptivity to treatment. From reanalysis of the NCS data, Diala and colleagues (2001) found that African Americans with mental health problems reported more positive attitudes than did whites to seeking care, including greater comfort with the prospect of professional assistance. In another analysis (Diala et al. 2000), the investigators found unfavorable attitudes among African Americans who actually had sought professional assistance. This suggests that unpleasant experiences or ineffective treatments accounted for negative attitudes toward help seeking, rather than mistrust or aversion to treatment.

## Stigma

Despite an expectation that many ethnic minority communities regard mental illness as particularly stigmatizing, little research on the effects of stigma on service use by ethnic minorities has been forthcoming. In a six-state study, Corrigan and colleagues (2003) reported that 50% of persons with severe mental illness experienced stigma related to their illness. African Americans, Asian Americans, and gay and lesbian participants also reported high rates of discrimination due to their race or sexual orientation, thereby indicating that one source of stigma does not displace the other. Stigma related to mental illness among primary care clinic patients with depression has also been examined. In a diverse sample of insured English- or Spanish-speaking adults presenting at one of 46 primary care clinics for treatment of depression, Roeloffs and colleagues (2003) found that persons classified as of non-Latino and nonwhite ethnicity (primarily African Americans) were more concerned about the impact of stigma when a history of depression was disclosed than were persons of other ethnicities. Concern over stigma did not affect

use of mental health service, medical visits for emotional reasons, or appropriate use of antidepressant medication.

In one of the few intervention studies reported to date, researchers demonstrated positive effects in reducing stigma from a psychoeducation program adapted for Korean immigrants with schizophrenia in New York (Shin & Lukens 2002).

## Symptom Expression and Coping

Ethnic and cultural differences in mental illness expression remain a viable explanation for differences in access and continuity (Johnson & Cameron 2001). Lewis-Fernandez and colleagues (2002) linked a culturally defined syndrome, *ataque de nervios*, with dissociative symptoms and disorders. The finding implied that *ataque de nervios* might be a culturally sanctioned way to express professionally recognized forms of mental health-related distress. Focusing on high rates of diagnosed schizophrenia among African Americans and low rates of depression, one research team demonstrated that both African American and white clinicians evaluated some symptoms as having differential diagnostic significance when presented by persons who were African American or white (Neighbors et al. 2004). These differences might reflect differences in styles of symptom expression, although this was not determined. However, from confirmatory factoring of a widely used symptom checklist, another group (Chow et al. 2001) reported little evidence that symptom clusters differed for African Americans, Latinos, Asian Americans, and whites.

Conceivably, culturally preferred coping styles emphasize self-reliance and other characteristics that are incompatible with interpersonal help seeking, including—or perhaps especially—from mental health professionals. In a study of low-income residents of Puerto Rico, Ortega & Alegria (2002) reported that persons with both an assessed need for mental health treatment and high levels of self-reliance were far less likely to seek assistance from any source. Kung (2003) found that Chinese Americans who needed mental health treatment and who scored high on the challenge dimension of hardy personality configuration were less likely than others to seek help from medical or specialty mental health sources.

## Integrating and Tailoring Explanation: Toward Comprehensive Theoretical Accounts

Several studies developed and evaluated comprehensive explanatory models sometimes chosen to suit the particular cultural group at hand. Abe-Kim and colleagues (2002) tested several hypotheses about Chinese American help seeking by reanalyzing data from the Chinese American Psychiatric Epidemiological Study. Along with confirming established correlates, including treatment need and insurance coverage, they found that family conflict, possibly because of its special importance in cultures with collectivist values, predicted use of medical and mental health services. Language barriers, stigma, and knowledge about services proved unrelated.

Yeh and colleagues (2003) asked Asian and Latino parents about barriers to mental health care for their children, and reported an unexpected and complex interplay of factors. Parents who were more acculturated reported that there were more barriers to specialty mental health care that prevented them from seeking care for their children. The investigators surmised that less-acculturated parents might have been less willing to complain about factors preventing them from seeking care.

In a study of continuity, McCabe (2002) reported no relationship between treatment dropout and stigma or in the discrepancies between culturally based client expectations about mental health treatment and the treatment experience itself. Thus, McCabe (2002) did not find that expecting therapists to be more directive than they were was significantly related to dropping out. Predictors of retention included ethnic matching of clients and consumers, parental education level, belief in strict discipline (rather than treatment) in response to mental health problems, and perceived barriers to treatment.

Alegria and colleagues (2004) analyzed data from 2000 Puerto Rican households to investigate levels of need and correlates of services use. They reported that the children most likely to be treated were those who suffered the greatest functional impairment because of mental illness (especially disruptive behavior problems), who had greatest difficulty with school work, and whose parents were most concerned. They noted that parents of untreated children had not made a link between disrupted functioning, mental illness, and treatment, and that lack of recognition might be more characteristic of some cultural groups than of others.

Yeh and colleagues (2003) recommended using qualitative methods to begin to unravel unexpected complications in understanding how cultural factors come into play in help seeking. Following a mixed qualitative-quantitative approach, Hines-Martin and colleagues (2003) elicited individual, environmental, and institutional barriers to care, 14 in all, from low-income African Americans. In another qualitative study, barriers facing American Indian and Latino veterans were identified via open-ended interviews with volunteer behavioral health workers in the Veterans Administration system. Characteristics of the Veterans Administration system were considered greater impediments to care than were characteristics of veterans or their communities (Westermeyer et al. 2002). Results from the little qualitative research available indicate that when researchers ask consumers and key informants to respond in their own words, they identify a wider scope of barriers than are otherwise identified.

Progress is being made in improving the fit between clients from ethnic and culturally diverse backgrounds and mental health services, but cultural factors continue to result in barriers to quality mental health services (see Kouyoumdjian et al. 2003). Acculturation remains a first and leading explanatory variable when thinking about assessing cultural congruence between services and service systems on the one hand, and culturally diverse clients on the other. Vega et al. (1999) and Peifer et al. (2000) found that U.S.-born Mexican Americans were more likely to seek help from medical and specialty mental health sources, whereas Mexico-born Mexican Americans were more likely to seek help from informal providers (folk

healers, spiritualists, astrologers, etc.). Reanalyzing data from the Chinese American Psychiatric Epidemiological Study, Kung (2003) reported that in the sample as a whole, more-aculturated Chinese Americans were more likely to seek outside assistance for mental health problems. Among Chinese Americans suffering from diagnosable mental illness, however, less-aculturated persons were more likely to seek assistance.

Psychologists have made important theoretical and methodological strides in their effort to better understand acculturation (Cabassa 2003a, Chun et al. 2003). However, the ready availability of acculturation theory and assessment methods does not eliminate or even reduce the need for researchers to formulate and test theories tailored to understanding how specific cultural influences affect access and continuity.

Another common default explanation for access barriers and poor continuity is lack of culturally sensitive therapy. Treatments tailored to accommodate differences in interdependence, spirituality, discrimination, and ethnic and cultural variations can provide a welcome addition to the treatment armamentarium (Hall 2001). At present, however, many remain to be shown efficacious and effective (Hall 2001). Nor can their success at increasing the use of specialty treatment and facilitating improvements in continuity be taken for granted.

## POLICIES, SYSTEMS, ORGANIZATIONS, AND COMMUNITIES

Structural characteristics of the mental health services system—for example, whether mental health specialists are even available—greatly affect access and are likely to affect disparities. After studying nationwide disparities in children's access to mental health care, Sturm and colleagues (2003) concluded that “differences in the rates of use or unmet need are not driven by differences in the racial/ethnic or socioeconomic makeup across states but more likely are the result of differences in state policies and health care market characteristics. These state policies and health care market characteristics can interact with sociodemographic characteristics and affect how effectively resources are used” (p. 308). Little research has addressed the impact of policy-related or system-level mediators or moderators of disparities.

### Insurance

Lack of insurance is a widely invoked structural explanation for minority-white differences in mental health care access. Differences in insurance coverage are pronounced: African Americans are almost twice as likely as whites, and Hispanics almost three times as likely as whites, to be uninsured (Smedley et al. 2003). Critics of the current patchwork system have proposed universal coverage to eliminate lack of coverage, usually with full mental health benefits (U.S. DHHS 2001).

However, research indicates that although wider insurance coverage for mental health treatment would increase access by reducing the price of treatment (U.S. DHHS 1999), it would not eliminate disparities. Reanalysis of data from the NMES indicates that, perhaps because of cultural and other barriers, minority persons are less inclined than are whites to seek mental health care when they receive mental health coverage or when their coverage increases (Thomas & Snowden 2001).

Much public-sector care—such as that in which ethnic minorities and culturally diverse populations are overrepresented—is funded by Medicaid, a federal-state program that covers a varying mix of services on a state-by-state basis. Nationwide, disparities are smaller in many Medicaid-financed, public-sector programs that necessarily treat many minority persons (Snowden & Thomas 2000). In the South Carolina public behavioral health care system, for example, differences in need between African American and white women largely determined differences in treatment patterns (Jerrell et al. 2002). Pronounced regional differences found in access and disparities (Alegria et al. 2002, Sturm et al. 2003) may be attributable to differences in state Medicaid policy, including the scope of care provided and ease of access to Medicaid benefits.

## Managed Care

Public and private programs have been transformed over the past decade by the widespread introduction of programs to control utilization and practice patterns, known collectively as managed care. Managed care contracts often include provisions such as capitation—under which administrators or clinicians are paid a fixed fee for treating clients—that transfer financial risk to mental health administrators and clinicians, thereby providing them with incentives to hold costs down.

Critics (e.g., Mechanic 2003) are concerned about the transfer of responsibility for public sector consumers and about consequences for the public sector's traditional role as provider of mental health care of "last resort," upon whom ethnic minority and culturally diverse populations are especially dependent. Few of these or other studies have considered the possibility of differential impact on racial and ethnic minority populations, and results on the impact of managed care have been inconclusive (Snowden et al. 2003).

Elsewhere, according to the Institute of Medicine, evidence indicates "ethnic minority patients are less likely to have a regular provider, are more likely to be denied claims, and are less satisfied with many aspects of the care they receive in managed care settings" (p. 152). Those with reservations propose that managed care and capitation will increase well-documented and troubling disparities.

## Limited English Proficiency

For persons with limited English proficiency, the "language barrier" is an important deterrent to receiving care (Sue et al. 1991), and efforts to reduce it go beyond the clinician-client level. Existing federal law requires that all persons eligible for Medicaid and Medicare have equal access to services, regardless of their primary

language. Title VI of the Federal Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to limited-English-proficient persons that are limited in scope or lower in quality than those provided to other persons. Following from Title VI, state Medicaid agencies, managed care plans, and others that receive funds from the federal DHHS must take adequate steps to ensure that individuals receive the language assistance necessary to afford them equal access to services, free of charge. Federal DHHS suggests implementation of the following: assessment of language needs of the population to be served; staff training; monitoring; provision of trained interpreters; translation of written materials; and notification of beneficiaries regarding their right to language assistance and the availability of such assistance free of charge (Alcalde & Morse 2000). Differences in Title VI implementation potentially have profound effects on ethnic and cultural access, but little evidence on the issue exists.

### Community-Based Organizations and Ethnically Focused Mental Health Programs

Public mental health authorities often contract with community-based, multiservice organizations that emphasize outreach into ethnic minority communities. The specialized, ethnically focused mental health programs operated by community-based organizations appear to have higher retention rates, greater continuity, and, in selected instances, higher levels of client improvement (Chow & Wyatt 2004, Kouyoumdjian et al. 2003, Leong & Lau 2001). Evidence indicates that in such programs organizational factors—more than clinical factors—account for beneficial results, conceivably because cultural influences are communicated through organizational norms and operational procedures (Snowden 1998).

Ethnically focused programming includes inpatient care, and recent research focuses on assignment to ethnically focused inpatient units. One group of investigators (Matthews et al. 2002a) hypothesized that assignment to ethnically focused units would eliminate widely observed differences in diagnosis because staff would be better attuned to subtleties of culture and community and would better avoid diagnostic errors. With few exceptions, the hypothesis was not supported. For example, African Americans assigned to an African American–focused unit continued to have relatively high rates of schizophrenia diagnoses and low rates of depression diagnoses. On the other hand, ethnic minority clients assigned to an ethnically focused inpatient unit were more likely than others to be referred to outpatient or residential treatment, although there were no postdischarge differences in time to rehospitalization (Matthews et al. 2002b).

To understand their possible role in reducing disparities, more research is needed on the impact of ethnically focused programs, and other community-based mental health programs, on access and improvement by minority and other clients. Most helpful would be studies that identify specific organizational variables—structural characteristics and characteristics of organizational culture and climate—and link them to entry, continuity, and improvement.

## Local Intervention, Local Policy, and Local Impact of National Policy

Snell-Johns and colleagues (2004) conducted a comprehensive review of strategies for overcoming access barriers and decreasing attrition for ethnic minority and other vulnerable families in need of treatment. They focused on theoretically plausible service structures and procedures that could be controlled by program administrators and practitioners. After reviewing research literature, they concluded that providing services in recipients' homes, in multifamily therapy groups, and through self-directed or video-based interventions appeared to be effective strategies for increasing access. Other strategies for increasing access—including providing transportation, providing child care, and reducing treatment costs—had not been adequately tested. For reducing attrition, they found that providing direct incentives for attendance appeared to be effective. Too little evidence was available to evaluate the impact of other interventions proposed in the literature, including shortened waiting time, brief intervention, and strategies targeting therapist-client incongruent expectations.

National and state policies can indirectly impact the access of ethnic and culturally diverse groups to mental health care. As reported in Vega & Lopez (2001), Fenton and colleagues (1996) detected a drop in mental health care following the passage of California Proposition 187, which tightened restrictions on undocumented migrants to California.

Along with social and economic conditions, the nature and operating characteristics of programs administered by the mental health treatment system have a demonstrable impact on rates of psychiatric emergency room use. One study (Catalano et al. 2003) found that both closure of an outpatient clinic and conducting outreach to homeless persons were associated with increased rates of psychiatric emergency room use, whereas operating a mobile crisis team and a case-management program addressing substance abuse problems were associated with decreased rates of psychiatric emergency room use. Research-based knowledge on local conditions can pave the way to interventions that target disparity reduction (Aguilar-Gaxiola et al. 2002).

## CONCLUSION

We continue to observe ethnic and cultural disparities in access to mental health care, but we cannot yet adequately explain them. Well-founded understanding is important to guide outreach programming, incentive management strategies, program design efforts, and increased practitioner awareness interventions that are needed to overcome disparities in access as well as to enrich theories of culture and mental health.

Researchers must design and conduct more studies of treatment-seeking pathways that favor nonspecialty sources of assistance, improve trust and treatment receptiveness, eliminate stigma, and accommodate culturally distinctive beliefs

about mental illness and mental health and styles of expressing mental health-related suffering. The existing body of knowledge is often inconsistent and even paradoxical. More studies are needed that are formulated with theoretical clarity and conducted on representative community samples. Qualitative studies are needed, too, to permit us to observe help-seeking processes at a high level of detail.

The scope of investigation must also be enlarged to allow for more intervention research. Strategies must be conceived and evaluated that promote access and continuity to ethnic and culturally diverse communities.

Studies are needed that encompass the human services sector where the most vulnerable ethnic minorities and persons from culturally diverse backgrounds are most likely to receive care or to be referred for care, as well as studies of how policies governing the organization and financing of the mental health system affect disparities. Policies are modified regularly, and if adjusted to encourage mental health access by persons lacking access because of ethnic background or culture, would provide the greatest opportunity for wide-scale improvement.

A variety of options to support research on minority access to mental health care is available to clinical psychologists and others. The Agency for Healthcare Research Quality (AHRQ) leads the federal effort in health services research funding. The AHRQ—along with the various branches of the NIH and the Substance Abuse and Mental Health Services Administration—incorporates minority access issues into special funding initiatives as well as by including racial and ethnic minorities among priority populations (AHRQ 2002), and through mandates not to exclude ethnic minority populations unless scientifically justifiable (National Institutes of Health 2002). Despite the attention given to disparities in access by these federal agencies and other private foundations and endowments, a relatively low percentage of funding is sought and awarded specifically toward the improvement of ethnic and racial access to mental health services. For example, since the publication of the 2001 Surgeon General's Report, the AHRQ website's list of funded mental health grants lists only a handful of funded studies where understanding culture and ethnic minority access and intervention is a primary focus. By taking advantage of these and other opportunities, we can provide a solid empirical foundation from which to improve access and quality of mental health care for ethnically and culturally diverse populations.

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