Disparities in Mental Health Status and Care

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Mental disorders:

1. Are among the most prevalent classes of chronic diseases in the general population.

2. Co-occur within themselves, with substance use disorders, and with many medical conditions.

3. Typically have much earlier ages of onset than other chronic diseases.
Magnitude and Impact of Mental Disorders

Mental disorders:

4. Only a minority with mental health needs receive treatment in the preceding year.

5. Are among the most disabling of all chronic health conditions.

6. Are associated with significant adverse societal costs.
49.9% of the surveyed people received at least one lifetime diagnosis

Source: Kessler et al, 2005
Comorbidity

**Definition**: the presence of more than one mental disorder within the same period of time.

- **41%–65%** of those reporting a lifetime substance disorder had at least one other psychiatric disorder.

- **51%** reporting one or more psychiatric disorders also reported at least one substance disorder.

- **23%** of those in the NCS sample had three or more lifetime disorders.

Source: Kessler, 2004
Mental Disorders are Rarely the only Health Problem

- Chronic Physical Pain: 25-50%
- Cancer: 10 - 20%
- Neurologic Disorders: 10-20%
- Smoking, obesity, physical inactivity: 40-70%
- Heart Disease: 10-30%
- Diabetes: 10-30%

Source: Unützer, 2010
Median Age at Onset of Mental Disorders in the U.S. General Population (N=9,282)

- Anxiety: 11
- Mood: 30
- Substance: 20
- Total: 14

75% of severe mental disorders manifest by age 24!

Source: Kessler et al, 2005
Age at Onset of Mental Disorders

- The most serious mental disorders usually begin in childhood or adolescence.

- They are usually not severe when they begin.

- More typically, they become severe over time.

- Early-onset mental disorders are significant predictors of the subsequent onset and persistence of physical disorders.

Source: Kessler, Ormel et al., 2007
Childhood adversities may increase risks of early onset mental disorders, while both childhood adversities and early onset mental disorder may increase risks of a range of physical diseases in later life.
Treatment Gap in the U.S.

- Levels of **unmet need** (not receiving specialist or generalist care in past 12 months, with identified diagnosis in the same period)
  - Hispanics – 70%
  - African Americans – 72%
  - Asian Americans – 78%
  - Non-Hispanic Whites – 61%

Source: Alegria et al., 2006
Among the top ten main causes of disability, five are mental disorders:

- major depression
- schizophrenia
- bipolar disorders
- alcohol use
- obsessive-compulsive disorders

All five mental disorders appear by age 24!

Source: Kessler, Berglund, Demler, et al., 2005
Mental Disorders are Costly

- Estimated $247 billion in annual costs.
- Costs to the individual and family.
- Costs to multiple sectors – health care, education, justice, social welfare.
Mental Health Disparities in the U.S.

1. **Mental health status**: Are there differences in the prevalence rates of mental disorders among different racial, ethnic, and nativity groups?

2. **Mental health care**: For those with mental disorders, are there differences in receipt of treatment among different racial, ethnic, and nativity groups?
Analysis of the Collaborative Psychiatric Epidemiological Surveys (CPES)

- CPES dataset comes from three national surveys:
  1. The National Comorbidity Survey Replication (NCS-R)
  2. The National Latino and Asian American Study (NLAAS)
  3. The National Survey of American Life (NSAL)

- Represent the best national data that exist in the US.

- Used the WHO-CIDI to ascertain diagnoses according to DSM-IV criteria and also service use history.

- The final sample is N=15,120 adults of whom n=3,246 had past-year DSM-IV disorders.

Source: Kessler, 2004; Alegria et al., 2007; Jackson et al., 2007
**Prevalence of Past-Year Mental Disorders**
**US Adults by Ethnicity & Nativity**

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>African American</th>
<th>Latino</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size (N)</td>
<td>4,174</td>
<td>4,380</td>
<td>1,132</td>
<td>1,370</td>
</tr>
<tr>
<td>Past-Year Mental Disorder Prevalence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive disorders</td>
<td>10%</td>
<td>6% ***</td>
<td>6% **</td>
<td>9%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>15%</td>
<td>11% ***</td>
<td>7% ***</td>
<td>11% **</td>
</tr>
<tr>
<td>Alcohol or drug abuse or dependence</td>
<td>4.2%</td>
<td>3.1% *</td>
<td>0.1% ***</td>
<td>4.5%</td>
</tr>
<tr>
<td>Any of the above</td>
<td>22%</td>
<td>15% ***</td>
<td>11% ***</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: CPES Surveys 2001-2003. *p<0.05, **p<0.01, ***p<0.001, for test of difference with US-born whites.

Source: Aguilar-Gaxiola, Sribney, et al., 2011
# Prevalence of Past-Year Mental Health Service Use Among Those with Past-Year Disorders (US Adults by Ethnicity & Nativity)

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>African American</th>
<th>Latino</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td># of persons with past-year mental disorders (N)</td>
<td>1,389</td>
<td>844</td>
<td>130</td>
<td>351</td>
</tr>
<tr>
<td><strong>Medical doctors or medication</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist &amp; mental health hospitalizations</td>
<td>15%</td>
<td>14%</td>
<td>4% ***</td>
<td>10%</td>
</tr>
<tr>
<td>Other medical doctors</td>
<td>23%</td>
<td>15% **</td>
<td>6% ***</td>
<td>22%</td>
</tr>
<tr>
<td>Medications</td>
<td>37%</td>
<td>21% ***</td>
<td>11% ***</td>
<td>29%</td>
</tr>
<tr>
<td>Any of above 3 categories</td>
<td>45%</td>
<td>32% ***</td>
<td>14% ***</td>
<td>38%</td>
</tr>
<tr>
<td><strong>Non-MD clinicians or other human services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologists, social workers, counselors, mental health hotline, nurses, occupational therapists, or other health professionals</td>
<td>19%</td>
<td>15%</td>
<td>4% ***</td>
<td>20%</td>
</tr>
<tr>
<td>Religious or spiritual advisors</td>
<td>7%</td>
<td>9%</td>
<td>4% *</td>
<td>7%</td>
</tr>
<tr>
<td>Self-help groups</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Internet support groups</td>
<td>2.5%</td>
<td>0.6% **</td>
<td>0.2% ***</td>
<td>1.0% *</td>
</tr>
<tr>
<td>Any of above 4 categories</td>
<td>25%</td>
<td>23%</td>
<td>9% ***</td>
<td>25%</td>
</tr>
<tr>
<td>Any mental health service use</td>
<td>53%</td>
<td>41% ***</td>
<td>13% ***</td>
<td>45%</td>
</tr>
</tbody>
</table>

Source: CPES surveys 2001-2003. *p<0.05, **p<0.01, ***p<0.001, for test of difference with US-born whites.

Source: Aguilar-Gaxiola, Sribney, et al., 2011
1. Disparities are greater for medical doctor (MD) visits and medication than for non-MD clinicians or other human services.


3. The greatest disparity is for Caribbean black immigrants whose receipt of MD or medication is less than 1/3 US-born whites and their receipt of clinician and other human services is only slightly more than 1/3.

Source: Aguilar-Gaxiola, Sribney, et al., 2011
Past-Year Mental Health Service Use (MD or Meds) Among Those with Past-Year Disorders

1. Women are more likely than men to get medical care (MD or medications).

2. Those with public insurance are more likely to get mental health care in medical settings (MD or medications).

3. Persons with co-morbid mental disorders and persons with functioning difficulties due to mental health problems are more likely to receive medical care.


Source: Aguilar-Gaxiola, Sribney, et al., 2011
1. Women are more likely than men to get care in non-MD or other HSs.

2. Persons with co-morbid mental disorders and those with functioning difficulties due to mental health problems are more likely to receive care from non-MD or other HSs.

3. Overall, there were no significant ethnic by ethnicity group differences, with the notable exception of Immigrant African Americans who have significantly lower odds for receipt of non-MD or other HSSs.

Source: Aguilar-Gaxiola, Sribney, et al., 2011
The Heterogeneity of Latinos

- Latinos are highly heterogeneous in terms of:
  - life experiences
  - natural histories
  - the variety of cultures represented from North, Central, and South America
  - risks of psychiatric disorders

- Latino subgroups each manifesting different disparities in:
  - mental health status
  - access to care
  - service utilization
NLAAS Lifetime Prevalence of Any Mental Disorders for Latinos*

- For lifetime disorder:
  - Whites: 43.2%
  - Latinos: 29.7%

- Differences by Latino sub-ethnic group:
  - Puerto Ricans: 37.4%
  - Mexicans: 29.5%
  - Cubans: 28.2%
  - Other Latinos: 27.0%

- Differences by Latinos and nativity:
  - US-born: 37.1%
  - Immigrants: 24.9%

* Adjusted for age and sex

Source: Alegria et al., 2008; Cook, 2009
<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Latino</th>
<th>PR</th>
<th>Cuban</th>
<th>Mexican</th>
<th>Other Latino</th>
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</thead>
<tbody>
<tr>
<td><strong>US-Born</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MDE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US-Born</td>
<td>26.9</td>
<td>18.6</td>
<td>20.2</td>
<td>17.9</td>
<td>19.2</td>
<td>16.2</td>
</tr>
<tr>
<td>Immigrant</td>
<td>17.5</td>
<td>13.4</td>
<td>17.6</td>
<td>18.5</td>
<td>11.8</td>
<td>14.1</td>
</tr>
<tr>
<td><strong>Sub. Use</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US-Born</td>
<td>26.4</td>
<td>20.4</td>
<td>15.9</td>
<td>20.9</td>
<td>21.4</td>
<td>20.4</td>
</tr>
<tr>
<td>Immigrant</td>
<td>13.6</td>
<td>7.0</td>
<td>11.1</td>
<td>6.4</td>
<td>7.0</td>
<td>5.7</td>
</tr>
</tbody>
</table>

* Adjusted for age, sex, education & income

Source: Alegria et al., 2008; Cook, 2009
Who Utilized Services?

- 38% of U.S. born received care
- 15% of immigrants received care
- 9% of migrant agricultural workers received care

Source: Aguilar-Gaxiola, Vega, et al., 2000
Conclusions

- Mental health care disparities in status and in care exist in the U.S.

- They are a major public health problem at the national, state, and local levels.

- They should be seen in the context of a growing demographic diversity in U.S.

- They lead to significant burden of unmet mental health needs.

- This translates into ill health, premature death, diminished productivity, and social and economic disparities.
Implications for Policy and Practice

- Establishing policies that ensure available, culturally and linguistically appropriate and a diverse workforce trained to provide mental health care are necessary to address lack of access and quality of care issues.

- Improving treatment rates among ethnically diverse groups will need changes to healthcare that are based on the cultural, linguistic and social characteristics of these groups and how healthcare delivery systems and providers interface with them.

Source: Aguilar-Gaxiola, Sribney, et al., 2011
Implications for Policy and Practice (2)

- Improving access to community-based care for people with serious mental disorders is paramount.

- Institutional policies that expand hours of service, encourage flexible scheduling options, and allow time for family meetings within appointment time frames need to be adopted.

Source: Aguilar-Gaxiola, Sribney, et al., 2011
Overall Recommendations from the WHR 2001 Report

Steps that can be taken to promote better mental health:

1. Provide treatment in primary care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve communities, families, and consumers
6. Establish national policies, programs, and legislation
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support more research