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Identifying Targets on Which to Intervene in Order to Reduce and Ultimately Eliminate Disparities in Mental Health Services

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A wise “uncle” once said that when writing scientifically, it is essential to establish “blood on the tracks.” In order to convey the impact and make the argument compelling, the problem and the public health significance of addressing this problem need to be clearly articulated. Racial/ethnic, age, and sex disparities in mental health services use have been well documented. For the past 15 years, racial/ethnic health-care disparities have risen to the forefront of clinical and policy attention. Nevertheless, disparities in mental healthcare remain wider than in most other areas of health care services—especially in older adults.¹ The “blood on the tracks” has been established. Now is the time for action, and Byers et al.² provide a guide on potential directions for further inquiry. This study determined key predictors of mental health services use across the life course, and explored how racial/ethnic and sex disparities influenced these associations among younger (18–34 years), middle (35–54 years), and older (≥ 55 years) adults with mood, anxiety, and substance use disorders. Understanding how these key factors interact is vital for identifying targets on which to intervene in order to reduce and ultimately eliminate disparities in mental health services use.

The key factors that influenced use included marital status, health insurance, perceived family support, history of suicidal behavior, comorbid psychiatric disorders, chronic medical conditions, and perceived cognitive impairment. Although service use was low across the life course, the findings demonstrate that key factors such as chronic medical conditions and marital status influence use at specific stages of the life course, with racial/ethnic disparities affecting these associations with use across age. Byers et al.’s findings suggest that chronic medical issues may be strong motivators of mental health services use with greater age for racial/ethnic minorities.² This is consistent with the work that we have done.³ We found that Latinos and African Americans without a comorbid medical illness had especially low rates of mental health service use compared with their counterparts with a comorbidity. For Latinos and African Americans, the lack of a comorbid general medical illness may also limit exposure to the health-care system. This lack of exposure, combined with the high degree of stigma and differing mental health beliefs, may contribute to the especially low rates of mental health service use among Latinos and African Americans without a comorbidity. In addition, Byers et al.² found that the impact of marital status on services use

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across the life course was modified by racial/ethnic differences suggesting that mechanisms of coping with mental health issues vary due to underlying cultural differences. Taken together, these findings indicate two different patterns of use for racial/ethnic minorities. Comorbid medical illnesses may encourage use of services, whereas relationship issues may discourage use but encourage receipt of help from familial or cultural systems.

These results suggest that targeting key factors that impact use in particular age groups through educational and outreach services may support increased use of services across the life course by adults in great need of care. In other words, interventions need to be tailored according to the specific needs of the population being targeted. For example, Byers et al.² highlight the important role of comorbid general medical illness as a potential contributor to the use of mental health services for younger and older adults. Therefore, interventions to treat mental health problems with general medical health and wellness techniques could be an effective strategy to engage younger and older adults in mental health services. Such targeted health promotion interventions hold the potential to affect mental health services use and could also appeal to adults from racial/ethnic minority groups because these techniques may seem less stigmatizing and more culturally acceptable than typical mental health services. Furthermore, health promotion interventions can be tailored further for adults from racial/ethnic minority groups by adding a social support component since adults from racial/ethnic minority groups prefer to rely on family, friends, and community members for mental healthcare.⁴

The work of Byers et al.² is particularly relevant in the field of mental illness prevention. We are pilot-testing a multicomponent health promotion intervention called Happy Older Latinos are Active (HOLA).⁵ HOLA combines social and physical activation to engage participants in a physical activity routine as well as pleasant events scheduling to reduce risk for common mental disorders, prevent incidence and recurrence of common mental disorders, and improve health-related outcomes among at-risk older Latinos. The results of the study by Byers et al.² underscore the need for interventions that promote greater access to mental health services among adults from racial/ethnic minority groups and for interventions specifically designed according to patient's age. HOLA puts these results into practice in a real-world setting, extends them into the field of prevention, and highlights the significant impact such an intervention can have in lowering depression and anxiety vulnerability when it is relevant, respectful, and specific to the needs of the older Latino population.⁶

Lastly, one of the strengths of this study is the data set. The Collaborative Psychiatric Epidemiology Surveys (CPES) were initiated in recognition of the need for contemporary, comprehensive data about the prevalence of mental disorders, impairments associated with these disorders, and their treatment patterns from representative samples of majority and minority adult populations in the United States. Secondary goals were to obtain information about language use and ethnic disparities, support systems, discrimination, and assimilation in order to examine whether and how closely various mental health disorders are linked to social and cultural issues. The CPES may be old—the surveys took place between 2001 and 2003—but they provide the first (and only) national data with sufficient power to investigate cultural and ethnic influences on mental disorders.⁷ In an era of shrinking budgets for

research and increased competition for those scarce dollars, it is difficult to envision such a comprehensive epidemiological study being conducted in the near future. Until such a time comes, the CPES data set is the best we have, and we will be well-served to mine this rich data set, further enhancing our return on investment.

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