

REVIEW OF DISPARITIES IN THE MENTAL HEALTH CARE OF ETHNIC MINORITY PATIENTS

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SUMMARY

Background: Due to demographic changes, Western societies are increasingly multicultural and diverse. These changes lead to the issue of the equity of care for all groups of society, particularly for ethnic minorities. Within the context of medicine, it has been proven that doctors are sensitive to patient ethnicity, and that this in turn affects doctors' decision-making and the quality of their relationship with the patient. This leads to reduced access and quality of care for ethnic minority patients, which in turn magnifies ethnic inequalities in health care. Little is known about the extent of this issue within the specific field of mental health care.

Methods: We conducted a literature search within three online databases, focusing on two main questions: (I) What are the main types of disparity observed in the provision of mental health care for ethnic minority patients? and (II) How do mental health care providers contribute to disparities in the mental health status of ethnic minority patients?

Results: We identified a total of 164 articles relevant to our research questions, published between 1989 and 2013. Of these, only 29 were retained. The main findings are summarised in this paper.

Conclusion: Mental health care providers should be constantly aware of potential bias due to patient ethnicity and of the potential impact of this bias on the process of care if they want to act in the best interests of patients and avoid contributing to mental health disparities. The contribution of mental health care providers to these disparities is only one aspect of this complex social issue.

Key words: health inequalities - ethnic minority patients - mental health care disparities - mental health care provider bias

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INTRODUCTION

Multiculturalism and ethnic diversity are now a reality in Western societies (Inglis 2008). Within the field of health care, equity of care for ethnic minorities has become an important issue (Marmot et al. 2008). Disparities in physical and mental health status between ethnic minority groups and the rest of society are well documented and have been shown to persist even after controlling for confounding factors (Atdjian & Vega 2005, Mead et al. 2008). The mental health care system has been described as providing less qualitative care to ethnic minority patients when compared with non-ethnic minority patients. This has led some researchers to call for initiatives to improve services for minority groups (McGuire & Miranda 2008).

Within the context of medicine, it has been proven that doctors are sensitive to patient ethnicity and that this affects doctors' decision-making, recommendations, and the quality of their relationship with the patient (Dovidio & Fiske 2012, Lepièce et al. 2014, van Ryn 2002). This in turn leads to reduced access and quality of care for ethnic minority patients and consequently magnifies ethnic inequalities in health (Smedley 2003).

Access to and quality of mental health care is a complex issue, the study of which requires several levels of analysis (e.g. individual, organisational, and structural). In this paper, we will limit our analysis to the individual level. It has been suggested that ethnic/racial bias from mental health care providers may be one factor contributing to health disparities for ethnic minority patients (Smedley 2003, Snowden 2003).

In this paper, we review and summarise the literature in order to address the following two questions: (I) What are the main types of disparity observed in the provision of mental health care for ethnic minority patients? and (II) How do mental health care providers contribute to disparities in the mental health status of ethnic minority patients?

METHODS

We searched three online databases: MEDLINE, SCOPUS, and PsycINFO. We conducted a literature search using various combinations of the following search terms: "mental health care", "disparities", "ethnic/racial bias", "discrimination", "prejudice", and "ethnic minority patient", from the earliest records in these databases until 2013.

RESULTS

We identified a total of 164 articles, published between 1989 and 2013. A total of 29 articles met eligibility criteria. Findings regarding our two research questions are summarised below.

I. What are the main types of disparity observed in the provision of mental health care for ethnic minority patients?

The mental health care system is described as providing less qualitative care to ethnic minority patients when compared with non-ethnic minority patients

(Cook et al. 2007). Below, we describe the main types of disparity observed in the provision of mental health care for ethnic minority patients.

Utilisation of mental health services

The underutilisation of psychiatric care by ethnic minority patients was regularly reported to be a major factor contributing to disparities (Atdjian & Vega 2005). The striking underutilisation of mental health services by minority patients was often explained by issues of service availability and insurance coverage. It is true that the availability of mental health services depends on where a patient lives and that ethnic minorities are often concentrated in urban areas where they are less likely to find mental health services (Barksdale et al. 2010). Ethnic minority patients have also been described as lacking health insurance, which is an important barrier to seeking mental health care (Brown et al. 2000). However, other factors have also been reported to explain the underutilisation of mental health services by ethnic minorities. Services and providers are regularly described as lacking adaptability and often failing to take into account ethnic minority patients' preferences in styles of receiving assistance. It has been argued that the development of mental health services takes place with limited incorporation of minority groups' values and beliefs. Such services may therefore not be perceived as helpful and some minority communities have developed a mistrust of the services available (Appleby 2008).

Diagnosis

There is evidence of clinician bias when it comes to diagnosing mental illness in ethnic minority patients (López 1989). Ethnic minority patients are more likely than white patients to be diagnosed with severe mental illness (West et al. 2006). The literature concludes that there is inadequate detection of psychiatric conditions for ethnic minority patients by mental health providers (Atdjian & Vega 2005). For example, studies have reported that clinicians overvalue psychotic symptoms and schizophrenia but undervalue affective disorders among African Americans (Baker & Bell 1999, Minsky et al. 2003). Two reasons for diagnostic bias in psychiatric evaluations of ethnic minority patients are given: clinician bias, which is a lack of adherence to diagnostic criteria during psychiatric evaluations, and cultural bias, which is the overlooking or misinterpretation of true ethnic/racial differences in symptom expression by diagnosticians (Whaley 2004). There is considerable evidence of clinicians having more difficulty diagnosing ethnic minority patients than non-ethnic minority patients (Sohler & Bromet 2003).

Treatment

Disparities in pharmacological treatment, in terms of initiation and adequacy, have been described for ethnic minority patients when compared to white patients (Keyes et al. 2008). There is a tendency by clinicians to overmedicate ethnic minority patients (Segal et al.

1996). During consultations, clinicians devoted significantly less time to the evaluation of minority patients (Hogue et al. 2000). Ethnic minority patients benefitted from fewer outpatient psychiatric visits and less psychotherapy and when they did access psychiatric treatment, early dropout was a persistent problem (Chen & Rizzo 2010). Ethnic minority patients are significantly more likely than other patients to be hospitalised in specialised psychiatric hospitals (Snowden & Cheung 1990). Psychiatrists were found to be more likely to hospitalise ethnic minority patients against their will than their white counterparts, and ethnic minority patients also had a higher risk of seclusion once hospitalised, independently of appropriateness and clinical factors (Strakowski et al. 1995).

Communication

Interethnic medical consultations may be characterised by ineffective or poorer communication, and this is a major barrier in the relationship between mental health care providers and ethnic minority patients (Ashton et al. 2003). The most obvious barrier is language. Even when doctor and patient speak the same language, they may use and interpret terms, idioms, and metaphors differently (Kim et al. 2000). The problem of ineffective communication caused by language difficulties often remains unsolved, leading to frustration and exasperation, with patients feeling neglected (Scheppers et al. 2006).

II. How do mental health care providers contribute to disparities in the mental health status of ethnic minority patients?

Research in the field of social psychology has provided several explanations for the way in which health care providers contribute to disparities in health care. The main explanations encountered in our review are summarised below.

Social categorisation

Doctors effectively categorise their patients automatically into social groups based on ethnicity. When a patient is assigned to a social group, stereotypes and prejudices associated with this group are activated and also assigned to the patient. These stereotypes then influence the doctor's perceptions and expectations about the patient. This process affects the doctor's assessment, leading to misdiagnoses and inappropriate treatments (Penner et al. 2013). The problem with stereotype activation is that negative expectations are generalised to the entire social group, regardless of whether particular individuals actually possess stereotypical characteristics (Burgess et al. 2004). Furthermore, doctors' stereotypes about patients may be ultimately confirmed, thus resulting in a vicious circle. For example, doctors who expect their ethnic minority patients to be less adherent to their medical recommendations may devote less time to discussing the condition and treatment with them, resulting in ethnic minority patients having a

poorer understanding of recommendations and thus reduced adherence. This phenomenon in the medical encounter is described as the self-fulfilling prophecy (Penner et al. 2013).

Unconscious reactions

Researchers have suggested that health care professionals may be biased even in the absence of their own intent or awareness (Moskowitz et al. 2012). During interracial interactions, racial biases may occur implicitly, without intention or awareness (Dovidio et al. 2008). Researchers have found that white people who sincerely want to behave in a non-prejudicial manner frequently manifest anxiety and enhanced levels of arousal when interacting with minority group members and members of stigmatised groups (Blascovich et al. 2001). This means that even egalitarian doctors may be uncomfortable when interacting with minority or stigmatised patients (Burgess et al. 2004).

Doctors, like all humans, may be more likely to rely on stereotypes when facing out-group members (Burgess et al. 2004). Out-group members are simply people who are perceived to be “not like us”, a category that includes people who do not belong to our ethnic group. Patient characteristics, including ethnicity, are associated with doctors’ interpersonal behaviours, such as nonverbal attention, empathy, courtesy, and information giving (Cooper et al. 2006, Peck & Denney 2012). When stereotypes are activated, unconscious reactions occur. This often takes place outside of conscious awareness, a process known as implicit cognition (Burgess et al. 2004). Within the context of medicine, the implications of these principles are that white doctors may be more likely to attribute negative behaviours by a white patient (such as failure to comply with instructions) to situational factors (e.g. confusing instructions), while that same behaviour from an ethnic minority patient may be more likely to be attributed to dispositional factors (e.g. low level of education) (Burgess et al. 2004).

Negative feelings that develop towards other groups are also rooted in fundamental psychological processes. The categorisation of people into in-groups and out-groups may contribute to aversive racism (Whaley 1998). Aversive racism is considered to be a subtle form of bias. Aversive racists consciously endorse the principles of racial equality and therefore consider themselves to be non-prejudicial. Nevertheless, they also simultaneously possess unconscious negative feelings and beliefs about particular minority groups (Whaley 1998). These implicit biases are manifested in subtle, often unintentional forms of discrimination that produce less favourable outcomes for ethnic minority patients (Dovidio et al. 2008, Whaley 1998).

Unconsciously activated emotions may influence the tone of medical encounters (Burgess et al. 2004). For example, in one experiment, subliminal exposure to photographs of black people, as opposed to photographs of white people caused naive participants to unknow-

ingly behave in a more hostile manner toward their partners in a subsequent word-guessing game (Chen & Bargh 1997). If we apply this principle to interethnic medical encounters, it may be that white doctors unknowingly feel and communicate more negative affect toward their ethnic minority patients, who will show more negative affect in return. As these processes occur below the level of awareness, doctors may then judge their minority patients to be less friendly and less agreeable (Burgess et al. 2004).

DISCUSSION

In this paper, we review the literature in order to address two questions. Firstly, what are the main types of disparity observed when considering the provision of mental health care for ethnic minority patients? Secondly, what is the role played by mental health care providers regarding disparities in the mental health status of ethnic minority patients? Our results showed that, when considering the mental health care of ethnic minority patients, there are at least four main areas where disparities occur: the utilisations of mental health services, provider diagnosis, provider treatment and recommendations, and provider-patient communication. Ethnic minority patients seeking mental health care are likely to be affected in at least one of these areas. The literature provides several potential explanations for how mental health care providers may contribute to disparities in the mental health status of ethnic minority patients. Stereotypes stem from the cognitive process of social categorisation, which is necessary to make sense of other people and to cope with the complexity of our environment (Macrae & Bodenhausen 2000). However, these “natural” cognitive processes can backfire, leading to bias and prejudice from mental health care providers towards ethnic minority patients. The context in which the medical encounter occurs is particularly important because social categorisation is strengthened by cognitive load and uncertainty. Moreover, mental health care providers may be affected by a set of unconscious reactions and negative feelings about ethnic minority patients that ultimately lead to reduced quality of care for these patients.

Doctors may be particularly vulnerable to the use of stereotypes in forming impressions of patients due to time pressure, brief encounters, and high cognitive loads due to having to manage complex tasks and make important decisions (van Ryn & Burke 2000). This is particularly reinforced in the field of mental health care. Indeed, psychiatric practice is practically defined by its complexity and uncertainty (Holloway 1997). Some have argued that the ambiguity surrounding mental illness and the appropriate treatment of it invites bias (López 1989). This ambiguity may be reinforced by the role played by culture in interethnic medical encounters. It has been shown that patients’ culture shapes the expression of mental illness (Nichter 2010).

In this paper, we focused on the provider bias hypothesis, which supposes that providers contribute to disparities in the mental healthcare of ethnic minority patients. But mental health care providers cannot be solely blamed for the disparities observed in the provision of mental health care to ethnic minorities and the disparities in the mental health status of ethnic minority patients. In this type of analysis it is important to take the wider context into account (Pager & Shepherd 2008). There are many other potential causes of these disparities, some of which are related to the societal and organisational contexts. Provider bias leading to disparities may therefore only be expressed under certain contextual conditions (Petersen & Saporta 2004, Reskin 2000). Other factors continue to prevent ethnic minority individuals from seeking treatment and lead them to forego established mental health care services. Provider bias is one cause of disparities, but it must be considered within a wider context. The other main causes of disparities in mental health care for ethnic minority patients are lack of familiarity of those patients with mental illness-related concepts, preference for interpreting mental health problems in terms of spiritual or other culturally-sanctioned ideas, stigma, and coping habits that stress self-reliance and family reliance (Nichter 2010). These other causes have not been explored in this study. The contribution of bias relative to other causes is difficult to assess, and this is one limitation of our paper.

CONCLUSION

Disparities in mental health care are prevalent throughout the world. However, we believe that they are not inevitable and can be reduced. Many papers provide practical recommendations for reducing the contribution made by providers to disparities – interested readers are directed to these papers. In this paper, we emphasise that the contribution made by providers to disparities is only one aspect of this complex social issue. Many other potential alternative explanations must also be taken into account. Mental health providers should be aware of their role when dealing with ethnic minority patients, in order to avoid contributing to disparities. This topic is complex and requires doctors to be open and aware, particularly those working with ethnic minority patients or indeed any patients that fall outside of the scope of the “ideal patient”. Action should be taken at the individual level (i.e. the provider) but also and primarily at the collective level (i.e. the organisational, financial, and legal levels). It is our collective responsibility as health care professionals to combat disparities in the provision of mental health care, in the pursuit of social justice.

Acknowledgements: None.

Conflict of interest: None to declare.

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