Barriers to Mental Healthcare for African-Americans and the Importance of Population-Specific Assessment in Intervention Planning and Care Modeling

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Abstract

Title: Barriers to Mental Healthcare for African-Americans and the Importance of Population-Specific Assessment in Intervention Planning and Care Modeling

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Background: Mental health status affects all aspects of a person's health and well-being. There is a need for improvement in the disparity in mental healthcare that exists in ethnic minority populations to ensure equitable healthcare for all people, including ethnically diverse populations.

Aims:

(1) review the existing literature on barriers to mental healthcare in a specific subset of the ethnic minority (African-Americans)

(2) perform a frequency analysis of the specific barriers to accessing and receiving mental healthcare cited in the literature

(3) use the barriers identified to highlight the importance of their consideration in the development and planning for population-focused intervention and care modeling.

Methods: A literature review was performed using Ovid/Medline, Pubmed, ClincalKey, and Scopus databases. Barriers to mental health care for African Americans were identified and quantified through a frequency analysis.

Results: 25 barrier themes were identified through the literature review and described.

Conclusions: barrier recognition and population-based planning will be essential in promoting the success of future interventions and iterations of care models.

In February of 2000, a report from the Surgeon General was released recognizing the need for mental healthcare “designed and delivered in a manner that is sensitive to the perspective of racial and ethnic minorities”[1]. A 2001 follow up was published as a detailed account of the existing research on the needs of minority communities, highlighting the racial and ethnic disparities in treatment and recovery for these populations [2]. These reports were meant to act as an evidence base which would draw attention to the need for betterment of mental health in minority populations. However, nearly two decades later, minority populations are still experiencing significant disparities in access and treatment for mental health-related concerns. A 2017 systematic review looking at trends in racial/ethnic disparities between 2004 and 2012 showed an increase in past-year use of mental health services among all included ethnicities (White, Black, Hispanic, and Asian) populations. However, in comparison to White study participants who had a reported past-year mental health care utilization of 19.5%, Black, Hispanic, and Asian participants reported utilization as 9.2%, 8.7%, and 4.9%, respectively [3]. This disparity is evident in outcomes research in the realms of both quantity and quality of mental health care. Mental health status affects all aspects of a person’s health and well-being. Therefore, there is a need for an improvement in this disparity to ensure equitable healthcare for all people, including ethnically diverse populations.

In order to start improving this disparity we must identify the problems underlying the discrepancies in care between ethnicities. It is evident that these differences exist, but most interventions and models for care reform and integration that currently exist fail to recognize and address these differences during the planning and implementation

processes [4]. A lack of effort to recognize and reduce the existing barriers has led to interventions being deemed unsuccessful and inadequate for use in ethnically diverse populations [4]. So, the proper identification of barriers may be the first step in addressing some of the issues underlying why an intervention or care model is not working. However, one cannot assume that the barriers experienced by one ethnic minority population will be the same in another. So, it may be necessary to address each population on an individual basis and develop methods to adjust interventions and models of care based on the specific needs of that group.

The three aims of this paper will be to (1) review the existing literature on barriers to mental healthcare in a specific subset of the ethnic minority (African-Americans) (2) perform a frequency analysis of the specific barriers to accessing and receiving mental healthcare cited in the literature (3) use the barriers identified to highlight the importance of their consideration in the development and planning for population-focused intervention and care modeling. Hopefully, this paper will bring attention to some of the issues that are not being addressed in traditional interventions and care models and inspire people focused on reforming care to consider these issues when designing effective care.

Methods

Eligibility Criteria: Barriers to Mental Health in African-American Populations

The inclusion criteria consisted of studies focusing on predominantly human adult populations (age 18 or older) seeking care for serious mental illness (including major depressive disorder, bipolar disorder, schizophrenia, or any other disorder causing impairment in functioning). The date range for inclusion was publication between January 2008 and December 2017 and all included studies were in English and performed within the United States. No restrictions were included for the setting of the study. There was no restriction on study design. Both qualitative and quantitative studies were included. The focus of these studies must have been barriers to accessing and receiving mental healthcare with a predominant focus on African Americans.

Data Collection: Study Collection and Review

The databases used to identify studies were Pubmed, ClinicalKey, Ovid/Medline, and Scopus. Literature searches were performed using the terms. Searches were further narrowed based on the eligibility criteria. Studies for inclusion were stored in Endnote citation software. Studies that met criteria were then then reviewed for the presence of cited barriers to mental healthcare. Cited barriers were noted and categorized under each study.

Analysis

Once the cited barriers were identified within each study, themes were coded from the data. These themes were then used to categorize the identified barriers in each study. A frequency analysis of the data was then performed based on the themes and described in narrative form.

Results

Keyword Search

There were 627 articles identified on the pubmed, scopus, clinicalkey, and ovid/medline databases using the keywords “African American” or “Black” mental health care barriers.

Pubmed

Pubmed elicited 236 articles. There were 166 articles available from the past 10 years. There were 134 studies published in English on Human participants. Adults were studied in 104 articles. A screening of titles and abstracts for studies specifically focused on barriers to mental healthcare for African Americans left 6 articles for inclusion.

Scopus

There were 306 articles identified in the Scopus database. There were 219 articles available from the past 10 years. There were 170 studies published in English on Human participants. Adults were studied in 118 articles. A screening of titles and

abstracts for studies specifically focused on barriers to mental healthcare for African Americans left 4 articles for inclusion.

ClinicalKey

The ClinicalKey search produced 76 articles. All of these studies were published in the last 10 years, performed on human participants, and published in English. Adults were studied in 59 studies. A screening of titles and abstracts for papers specifically focused on barriers to mental healthcare for African Americans left 1 article for inclusion.

Ovid/Medline

Ovid/Medline database produced 9 articles, 7 of which included studies of human subjects and were published in English. Adults were included in 6 of the studies. Titles and abstracts were screened for studies specifically focused on barriers to mental healthcare for African Americans and 7 articles were included.

Article Inclusion

After all database searches were performed, selections were narrowed, and duplicate articles were eliminated, 10 articles were included in the final review and are described in figure 1.

Themes

The barriers identified in the ten included articles fell within 25 categories. The themes were coded as (1) access, (2) being strong, (3) care quality, (4) cost, (5) cultural mismatch, (6) discrimination, (7) distrust of medicine, (8) perceived treatment efficacy, (9) fear of consequence, (10) fear of medicine, (11) historical injustice in medicine, (12) maladaptive coping, (13) medical/mental health knowledge, (14) priorities, (15) provider bias, (16) religion, (17) resistance to “medicalization”, (18) resource awareness, (19) self-blame, (20) self-treatment, (21) status quo, (22) stigma, (23) taboo, (24) toxic masculinization, and (25) traditional screening. The specific articles citing each theme are illustrated in table 1.

A frequency analysis of barrier category citations was performed using excel and is illustrated in figure 2. The most commonly cited barrier to mental healthcare was stigma, which was cited in all ten included articles. Cost was cited in 80% of articles. Access, cultural mismatch, and medical/mental health knowledge were cited in 50% of the studies. Being strong, discrimination, distrust of medicine, maladaptive coping, and self-treatment were perceived as barriers in 40% of the articles. The barriers of fear of medicine, priorities, and resource awareness were identified in 30% of studies. Care quality, perceived treatment efficacy, fear of consequence, provider bias, religion, resistance to “medicalization”, and status quo were listed as barriers in 20% of articles. Finally, the least common barriers identified were historical injustice in medicine, self-blame, taboo, toxic masculinization, and traditional screening which were each cited in one article.

Discussion

Access

The theme of access has multiple components. Multiple articles cited that physical access was a major barrier to receiving mental healthcare. Rostain et al notes that the location of mental health providers can be heavily influential on the ability of a person to seek and receive mental healthcare [5]. The logistics of getting to and from appointments as well as lack of transportation also limits the ability to seek care[6]. However, access also encompasses the shortage of mental healthcare providers that now exists as well as the ability of a person to navigate the referral and follow-up systems in order to receive quality care[5]. A combination of these factors may lead to the inability of individuals to receive the healthcare they need.

Being Strong, Status Quo, Toxic Masculinization, Stigma. and Taboo

The concept of “being strong” is pervasive in the African-American community. Historically, the idea that you need to “tough it out” has been advocated in the African-American community and is considered the status quo. This likely relates back to the perceived notion that because ancestors made it through slavery, anything that you’re going through couldn’t possibly be as bad and you need to push through [5],[7]. Specifically, in regard to mental illness, there is a perception that black people do not get depressed and if you express your feelings about depression, you are weak or that depression is “for girls”[8] [9]. Ward et al. found that women reported accomplishment of “being strong” by denying mental illness altogether[10]. It is ideas such as this that lead

to people in need avoiding the acquisition of care. It is also considered taboo to talk about mental illness. This is something that is to be handled behind closed doors. The only people that should know about a person's mental illness is their family. The family then becomes the sole caregiver and source of treatment [11]. There is a perceived stigma and shame associated with mental illness. This exists in other populations, but is perceived to be particularly debilitating to be labeled as mentally ill revealed within the African American community [9].

Care Quality and Perceived Treatment Efficacy

Diminished quality of mental healthcare has been cited as a barrier to recovery. An explanation for this can be tied to limited access in some cases where the overwhelming caseload experienced by the few mental health facilities leads to poor quality of care for individuals [10]. Additionally, studies citing this as a barrier reported a perception that doctors providing care in these settings are less accomplished or knowledgeable. Patients reported past misdiagnosis a reason for not continuing to seek care [10]. Therefore, the quality of the care they are receiving is not as efficacious as that received by their non-ethnic minority counterparts [12]. Some patients also reported having bad past experiences with care or felt that treatment was not helping them at which point they stopped seeking care altogether [6].

Cost

While cost of care is a primary concern in most populations, there was an overwhelming agreement across studies relating lack of care utilization to cost. Patients perceived mental health services overall to be unaffordable. There were also multiple citations of lack of insurance preventing patients from seeking care [10]. Concerns were also brought up about lack of employment and lack of the availability of clinics tailored to meet the needs of patients with lower incomes [13].

Cultural Mismatch

Barriers related to cultural mismatch can be divided into different domains. One such domain is tied to the provider. Many people cited the idea that the doctor is likely to be a white male and therefore could not understand the situations that they are going through. There is also an element of mistrust of white providers that exists and prevents people form seeking care dor mental health problems[12]. Others reported that they'd be more likely to seek and follow up for care if the doctor were black[12]. Another domain of cultural mismatch is the belief that African Americans don't seek care for mental illness and any treatment is more likely to be targeted toward other ethnicities and won't work with an African American patient [12].

Discrimination and Fear of Consequence

Discrimination colors multiple aspects of the care experience in terms of creating barriers for those seeking care. Studies have cited inherent fear of rejection by providers as a main deterrent for care seeking [12]. There is also a belief that care will not be culturally sensitive and their concerns will not be heard because of their ethnicity

[10]. Additionally, a fear exists that they will be treated worse than both other races with mental illness and African Americans without mental illness if they choose to seek care. This brings about another point that discrimination is not simply limited to other ethnicities. There was reported fear that other African Americans will not accept anyone who claims or receives treatment for mental illness [14]. In line with discrimination is the fear of consequence that will occur if a person is labeled as having a mental illness. Some articles cited the fear of losing a job or being put in jail if a person is diagnosed with a mental illness. Others cited the idea of being removed from a family or having children taken away. It was stated that to avoid this, you must hide your illness at all costs.

Distrust of Medicine, Fear of Medicine, and Historical Injustice in Medicine

These themes encompass different concepts, but can all be tied back to the historical mistreatment of ethnic minority populations. The storied history of medical experimentation on African Americans still penetrates care to this day [5]. This infamous history has led to people being afraid to access of care. This is particularly pertinent in a field in which there are many unknowns. Treatment in psychiatry is not as well understood as treatments for non-psychologic ailments. This leads to skepticism and concern of being experimented on when medications are given for psychological disorders [12].

Resistance to "Medicalization", Self-Treatment, Self-Blame, and Maladaptive Coping

The idea of medicalization is that mental health problems are social or environmental issues and they aren't something that you go to the doctor for. For example, attention deficit and hyperactivity disorder (ADHD) is sometimes culturally perceived as a behavioral issue or "being hard headed" as opposed to something that is out of a person's control[5]. This leads to people not seeking care because they don't feel that a doctor can help with these types of problems. So, this can lead to self-treatment. This is the idea that it is your responsibility to deal with your mental problems on your own[6]. This concept can lead to maladaptive coping. This entails any mechanism used to suppress thoughts or feelings that are concerning or causing problems. For example, people with mental illness may outright deny that they have a problem. Others may self-medicate with alcohol or marijuana [9]. After a while, a person may either become comfortable with the idea of being in pain or end up with a condition worsened to the point of needing hospitalization. Alternatively, people who suffer from mental illness may blame themselves. The idea that mental illness is something you have to deal with on your own and if you aren't able to cope it is your fault [7]. All of these ideas prevent care seeking behaviors and can lead to worsening well-being of the person experience mental illness.

Priorities

Studies on African Americans cited mental illness being a low priority as a barrier to care. People studied identified other needs that superseded those of their mental health needs. These included, but were not limited to, food, stable housing, child-care,

work, and responsibilities within the household. These amongst other responsibilities were cited as precluding the ability of people who needed care to get seek it out [10].

Medical/Mental Health Knowledge and Resource Awareness

These barriers surround the idea of lack of knowledge. This may be due to lack of exposure or other external factors. Studies identified inability to recognize the signs and symptoms of illness as a major barrier to care [9]. There is also a discrepancy in the ability to recognize the need for care and the knowledge of where to get it. Multiple studies cited a lack of recognition of places to go for treatment of mental illness [13].

Religion

Religion has traditionally played a major role in the African American community. Religion can act as a barrier as some people believe that it is not up to them to seek out care. There is a belief that trust in God is all that you need for healing. This may prevent people from trying to access care because they believe that they will get better with prayer and belief alone. There is also a belief that religion supersedes medicine and that nothing a doctor can give someone will be more effective than prayer [9].

Provider Bias and Traditional Screening

Provider Bias and traditional screening are the two external barriers that were cited as contributing to the disparity in mental healthcare. Provider bias is the idea that providers are less likely to attribute a mental health diagnosis to someone that is African American[5]. Additionally, it is noted in one article that one of the reasons providers fail

to diagnose patients is the lack of a culturally sensitive tool for diagnosing patients that present with either masked or characteristically different than their white counterparts [8]. Both of these types of barriers have led to lower levels of diagnosis or misdiagnosis in patients who do present for treatment.

While not all themes and barriers identified in this review are limited to the African-American population, presentation of the more common barriers is made to act as an example of the vast assortment of needs that must be recognized when developing effective care strategies for a specific population. Additionally, barrier recognition should be a key component of the planning process for interventions and modeling of care integration so that adjustments can be made to deliver comprehensive care to the population being served.

Conclusions

There are interventions and models that are more conducive to adjustments in underserved populations. One such model is that of behavioral health and primary care integration (BHPCI). BHPCI has been emerging over the past decade as an important adaptation to the existing state of mental healthcare which, when widely implemented, may change how the field operates. Lee-Tauler et al. performed a systematic review of different interventions aimed at reducing the disparity in mental healthcare in ethnic minority populations. They found that one of the more effective models for improving care was that of BHPCI. However, while they praise the model itself, they note that continued vigilance in identifying social and cultural barriers to care will be essential in making the model effective for implementation in healthcare setting serving ethnically diverse populations [4]. This emphasizes the point that barrier recognition and population-based planning will be essential in promoting the success of future interventions and iterations of care models.

Time and time again we have seen initiatives in healthcare fail because they do not take pre-emptive regard for the diversity of the involved population and the unique needs of those that make it up. Mental illness in and of itself comes with stigma and barriers that we as a society have perpetuated to make accessing and providing care for these individuals difficult. So, when you take into account all of the other factors that affect ethnic minority subgroups within the mental healthcare seeking population, you can see that it becomes impossible to effectively develop and administer care for these individuals without first addressing the barriers and influential factors that exist first.

Therefore, anyone interested in developing and implementing new interventions and care models should devote time to researching and becoming familiar with the needs of their target population. They can then address these issues prior to implementation and work toward implementing more effective care and start to promote recovery in these communities that have suffered for too long.

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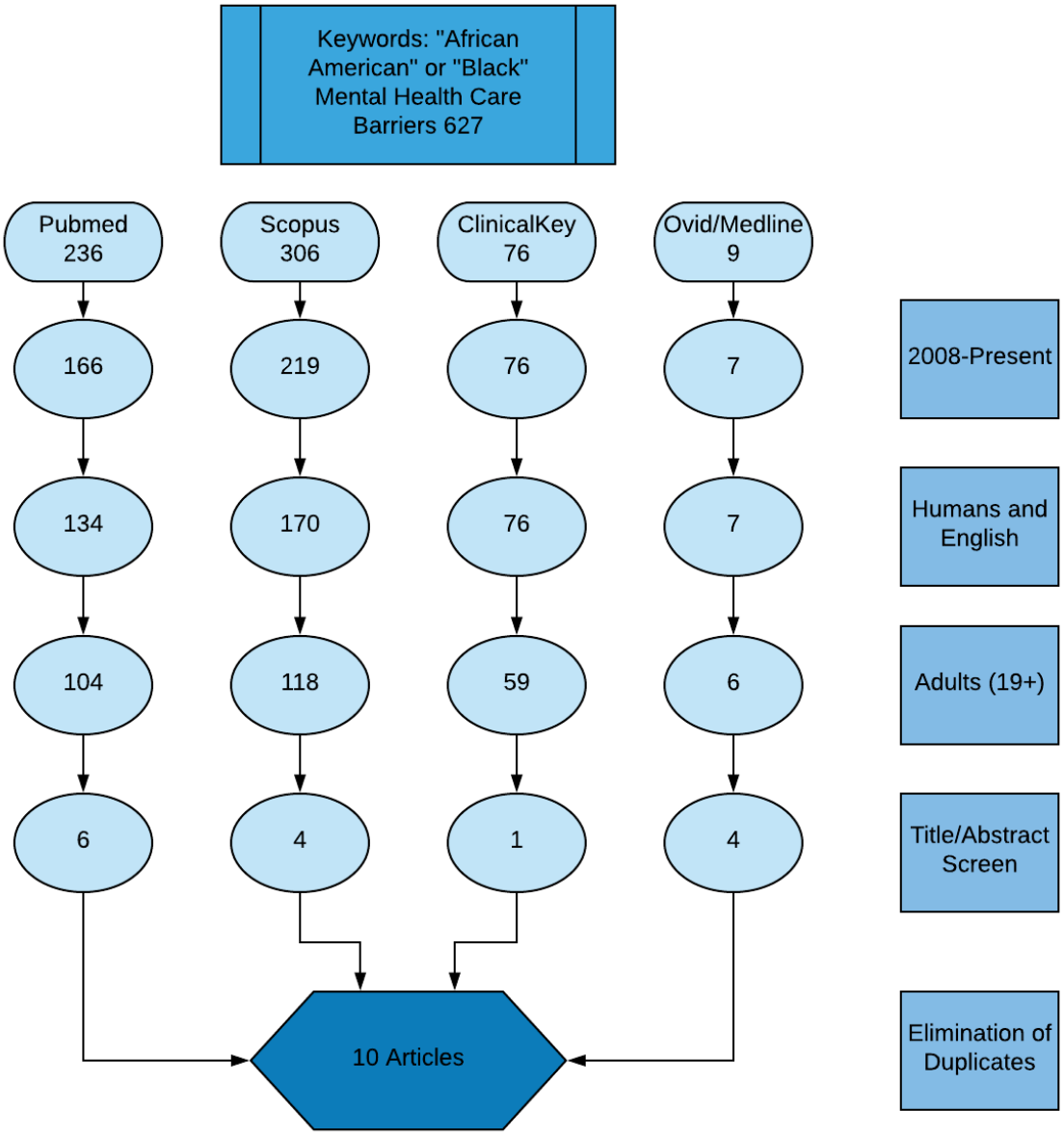

Figure 1. Flow Diagram of Article Inclusion Criteria and Selection

Barrier Category	Author Sorkin et al.	Rostain et al.	Perkins et al.	Doornbos et al.	Williams et al.	Copeland et al.	Conner et al.	Ward et al.	Davis et al.	Cruz et al.
Access		●		●			●	●	●	
Being strong		●				●		●		●
Care Quality								●		●
Cost	●	●			●	●	●	●	●	●
Cultural Mismatch					●	●	●	●		●
Discrimination				●			●	●		●
Distrust of Medicine	●					●	●			●
Perceived Treatment Efficacy				●	●					
Fear of Consequence						●				●
Fear of Medicine		●							●	●
Historical Injustice in Medicine					●					
Maladaptive Coping			●		●		●			●
Medical/Mental Health Knowledge					●	●	●	●		●
Priorities					●			●	●	
Provider Bias		●								●
Religion					●					●
Resistance to "Medicalization"		●						●		
Resource Awareness				●				●		●
Self-blame						●				
Self-treatment	●						●	●		●
Status quo							●	●		
Stigma	●	●	●	●	●	●	●	●	●	●
Taboo							●			
Toxic Masculinization			●							
Traditional Screening			●							

Table 1. Barrier Themes Identified by Article

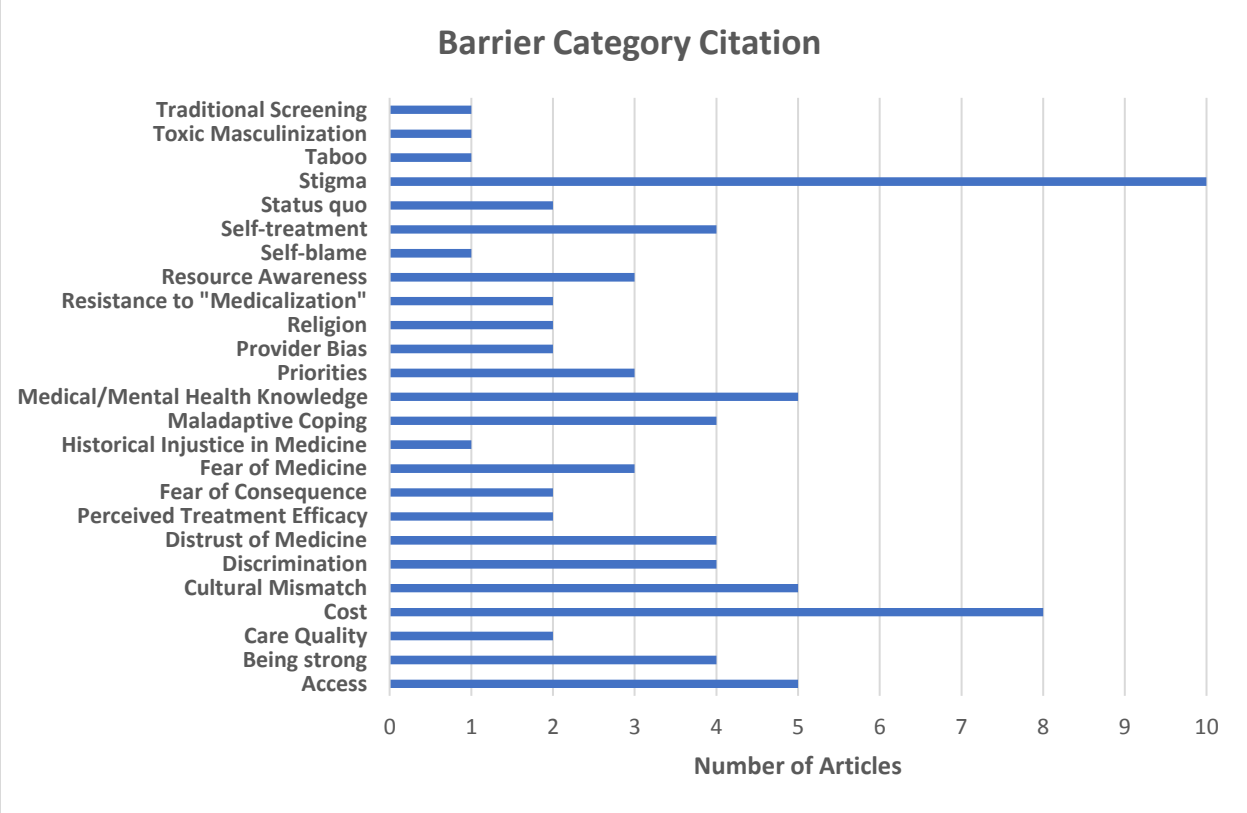

Figure 1. Frequency of Barriers Appearing in Selected Articles