Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment

6. Health Disparities

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Overview

This module presents information about the disparities in health care for people with serious mental illnesses compared to people with physical illnesses and also presents a review of some of the mediating factors that impact on these disparities. In addition to disparities between physical and mental health care, there are also disparities for racial and ethnic minority individuals with serious mental illnesses compared to non minority individuals with similar illnesses. These factors and the implications for treatment are discussed.

Learning Objectives

At the end of this module you will be able to:

- Discuss at least two differences in mortality observed for people with serious mental illnesses compared to people who do not have serious mental illness
- Identify and discuss at least three factors that contribute to the disparities in mortality for people with serious mental illnesses
- Identify at least three reasons that make lifestyle changes so difficult for this population
- Discuss at least three disparities in mental health treatment for people of racial and ethnic minority backgrounds compared to non minority individuals

Resources

- Lecture Notes
- Required Readings
- Lecture Notes Citations
- Sample Learning Activity
- Sample Evaluation Questions
- Additional Resources

Required Readings


**Activities**

Complete the following activities:

- Read the lecture notes
- Read the required readings
- Engage in a learning activity related to this module
- Evaluate students’ understanding of this module.
Lecture Notes

People with lived experience of serious mental illness are strongly encouraged to be part of the delivery of the curriculum including being active participants in the delivery of the lecture. Refer to the curriculum Instruction module for additional information.

Introduction

People with serious mental illnesses often receive less attention for both mental and physical illnesses in the health care system than people who do not have mental health disorders. There are also disparities in health care provision for individuals from racial and ethnic minorities with serious mental illnesses compared to non minority individuals with similar illnesses. Both of these disparities are mediated by the seriousness of the mental illness, the socioeconomic status of the individual, and whether or not the individual has a family or other support system to advocate for appropriate and timely health service provision. These disparities are evident when comparing morbidity and mortality related to mental illnesses versus physical illnesses, and when reviewing evidence related to services provided to racial and ethnic minority groups versus services provided to Caucasians.

Although these disparities were known by many for quite some time, the U.S. Surgeon General’s Report (U.S. Department of Health and Human Services, 1999) documented the differences in morbidity and mortality between people with physical and mental health disorders. The Report spawned a dramatic increase in funding for, and publication of research on these and related differences in health care access, utilization, and outcomes.

In addition to the differences between outcomes for people with physical and mental illnesses being complicated by factors such as race, ethnicity, culture, socioeconomic status, and gender, the interactions between and among these are complex and not always consistent. This module provides information about the disparities in health care that exist for people who have physical and mental illnesses, and considers the disparities in health care that exist for members of racial and ethnic minority groups, those from lower socioeconomic groups, and gender differences in health care provision.

Disparities in Provision of Health Care for People with Physical and Mental Illnesses

In 1999, the U.S. Surgeon General released the first report dealing with mental illnesses (U.S. Department of Health and Human Services, 1999). The Report noted that one in four Americans had a mental disorder and that two thirds of those did not receive treatment for their illness. The proportion of people with mental health disorders is highly similar throughout the world and similarly, most do not receive treatment (World Health Organization, 2001).
In the U.S., individuals with serious mental illnesses are now known to die an average of twenty five years earlier than those without these illnesses (Colton & Manderscheid, 2006; National Health Policy Forum, 2009; Parks, Svendsen, Singer & Foti, 2006; Roshanaei-Moghaddam & Katon, 2009; Schroeder & Morris, 2010). These deaths occur as a result of both natural causes such as cancer, cardiovascular diseases, respiratory diseases, and from unnatural causes such as suicide, injuries from violence or other traumatic events, and accidents (Mazi-Kotwal & Upadhyay, 2011). According to one recent report, “only 80% of people with schizophrenia die from natural causes, for example, compared with 97% of the general population. The higher rates of these deaths are largely attributable to accidents and suicide, which tend to occur more often in early than late adulthood” (Thornicroft, 2011).

In addition to the direct mortality from these conditions, people with serious mental illnesses receive poorer care and this can lead to morbidity and mortality from a wide range of conditions (Lawrence & Kisely, 2010). Most of the deaths from natural causes experienced by people with serious mental illnesses can be attributed to the effects of smoking and obesity, although other factors lead to illness and death as well. Yet, there are disparities in screening for diseases such as cancer in people with serious mental illnesses with obvious consequences for mortality (Howard, Barley, Davies, Rigg, et al., 2010).

There are far reaching societal implications as well. Inequalities in health care and other essential services undermine the social fabric that holds societies together and can ultimately lead to societal unrest and uprisings as seen recently in several countries around the world. Such inequalities can contribute to higher levels of mental illness, further impacting those involved and draining additional financial resources from health care systems that are increasingly under funded (Canadian Mental Health Association & Wellesley Institute, 2009). Although not a panacea for all of society’s ills, ensuring equity in physical and mental health treatment has implications for all segments of society, not just those affected by serious mental illnesses (Canadian Mental Health Association & Wellesley Institute, 2009; U.S. Department of Health and Human Services, 2011).

Deaths from Natural Causes – Smoking and Obesity

The excess rate of death from natural causes is primarily attributable to the effects of smoking and obesity, which lead to the respiratory diseases, cancers of many kinds, diabetes, and cardiovascular diseases, that ultimately cause premature disability and death (Parks, Svendsen, Singer & Foti, 2006). Although it is important to encourage lifestyle changes to reduce the risk of illness and death, there are complicated physiologic mechanisms at work that make smoking cessation and weight loss for this population exceedingly difficult.

Smoking

People with serious mental illnesses frequently have co-morbid substance use disorders and when taken together, these individuals account for almost half of the Americans who die annually from smoking related disorders (Schroeder & Morris, 2010). These individuals
also consume forty four percent of all cigarettes sold in the U.S. They have higher smoking rates and smoke more cigarettes per day (Lasser, Boyd, Woolhandler, Himmelstein, et al., 2000). Generally speaking, the more severe the mental illness, the higher the smoking prevalence (DeLeon & Diaz, 2005; Grant, Hasin, Chou, Stinson, et al., 2004; Lasser, Boyd, Woolhandler, Himmelstein, et al., 2000). Many of those with serious mental illnesses are very poor, and cigarettes consume a large proportion of their discretionary spending. An additional factor is that it is harder to achieve community integration when also experiencing stigma related to tobacco use (Schroeder & Morris, 2010).

The reasons why people with serious mental illnesses use cigarettes at such a high rate are many and varied. Cigarette smoking has been promoted in most cultures for generations and the U.S. is no exception. Cigarettes were given to U.S. soldiers during the World Wars, Korean War, and the Vietnam War, effectively addicting many who served. The practice was ultimately stopped due to pressure from health advocates (Blake, 1985) but the cigarette industry continued to lobby for preferential pricing in military commissaries around the world (Joseph, Muggli, Pearson & Lando, 2005; Smith, Blackman & Malone, 2007).

Research into the physiologic reasons for the high rates of smoking in this population is quite recent and the answers are not yet fully known. Genetic research has found an association with certain chromosomes and the nicotine receptor gene in people with schizophrenia and bi-polar disorder (Leonard, Adler, Benhammou, Berger, et al., 2001). This receptor gene has been implicated in impaired sensory processing in individuals with schizophrenia and schizoaffective disorder (Martin & Freedman, 2007). It has been hypothesized that there is a therapeutic effect of smoking for people with serious mental illnesses because nicotine is thought to normalize the deficits in sensory processing, attention, cognition and mood (George, Termine, Sacco, Allen, et al., 2006; Sacco, Bannon & George, 2004). Nicotine may also offer some relief from the side effects of psychotropic medications because smoking decreases blood levels of these drugs (Ziedonis, Williams & Smelson, 2003).

In addition to the above, smoking also offers the same rewards that it does for the general population, i.e., reduction in stress, anxiety, and boredom, and opportunities for social interaction with other smokers. However, the postulated genetic and neurobiologic mechanisms coupled with the highly addictive properties of nicotine, may be the reason why smoking is so prevalent and why, for this population in particular, it is so difficult to stop.

Obesity

Like smoking and the neurobiologic effects of nicotine, weight gain in people with serious mental illness is not a simple matter. The physiologic interplay between the causes of obesity, diabetes, and metabolic syndrome in people with serious mental illnesses is highly complex. While the ultimate effects of these factors (increased morbidity and mortality) are
known, the relationships between the underlying factors are only beginning to be understood.

Obesity is far more prevalent in people with serious mental illnesses than in the general population (Dickerson, Brown, Kreyenbuhl, Fang, et al., 2006; Parks, Svendsen, Singer & Foti, 2006). This can be due to a variety of reasons including poor nutrition, poverty making it difficult to purchase healthy foods, being homeless or inadequately housed making it difficult to prepare nutritious meals, cognitive deficits that make it difficult to understand and process the importance of healthy eating, and arguably most importantly, due to the iatrogenic effects of psychotropic medications, especially the second generation anti-psychotics, most particularly clozapine and olanzapine, which induce weight gain. Medications for bi-polar disorder such as valproic acid and lithium can also cause weight gain in people using these drugs, especially when used in combination with the second generation anti-psychotics.

Becoming overweight and obese leads to musculoskeletal disorders, pain and difficulties in getting adequate exercise, which in turn can lead to diabetes, insulin resistance, and cardiovascular disorders, and these can ultimately lead to metabolic syndrome with its increased risk of type 2 diabetes, heart attack, and stroke (Parks, Svendsen, Singer & Foti, 2006). The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study found that people using antipsychotic medications had much higher rates of metabolic syndrome than people in the general population (McEvoy, Meyer, Goff, Nasrallah, et al., 2005), putting them at significantly greater risk of the cardiovascular events that can result from the syndrome. Recent research has also suggested that second generation anti-psychotic medications may put people at risk of sudden cardiac arrest and death (Manu, 2011).

A recent meta-analysis of the research literature on this topic found that the prevalence of metabolic syndrome in people with schizophrenia and related disorders is consistent across treatment setting (inpatient vs outpatient), country of origin, and gender. Older individuals were at greater risk but those who had been ill the longest had the highest risk of developing the syndrome. When individual studies were evaluated, waist size was most useful in predicting metabolic syndrome and use of antipsychotic medication, especially clozapine, conveyed the highest risk. Those who did not use anti-psychotic medications were at lowest risk of this life threatening syndrome (Mitchell, Vancampfort, Sweers, van Winkel, Yu & de Hert, 2013).

Like smoking, losing weight for people taking anti-psychotic medications has proven to be very difficult. When the fact that psychotropic medications induce weight gain is considered, it is easy to understand why losing weight for this population has proven to be so extremely difficult. The following from an article entitled “Do we truly appreciate how difficult it is for patients with schizophrenia to adapt a healthy lifestyle?” sums these issues up concisely:
Their efforts to eat healthfully are undermined by the appetite stimulating effect of their medications. Besides, the atypical antipsychotic medications may also promote their responsiveness to external eating cues. For these patients quitting smoking is also harder than it is for individuals without schizophrenia. Nicotine provides greater stimulation and state-enhancement for them than it does for healthy individuals. They also have a poorer appreciation of the risks associated with smoking. Recurrent episodes of acute psychosis are frequent in patients with schizophrenia and disrupt any efforts they might make towards a healthful lifestyle. What is unique to patients with schizophrenia is their greater difficulty in breaking the pattern of unhealthful lifestyle and preventing its consequences due to factors related to their illness and its treatment (Hasnain, Victor & Vieweg, 2011).

Recent research has identified that pharmacologic interventions may be helpful in preventing or reducing weight gain associated with anti-psychotic medications (Mahmood, Booker, Huang & Coleman, 2013).

Because of the serious health implications associated with smoking and obesity, and the great difficulty that people with serious mental illnesses have in reducing these risk factors, individuals should be monitored very closely for early signs of respiratory and cardiovascular disorders, for cancers of all kinds, and provided with the newest and best pharmacologic interventions available.

Deaths from Unnatural Causes – Suicide and Violence

Although most deaths are from natural causes (Brown, Kim, Mitchell, & Inskip, 2010), people with serious mental illnesses are also at increased risk of dying from unnatural causes including suicide, violence and accidents, with the majority attributable to suicide and violence (Harris & Barraclough, 1997; Hiroeh, Appleby, Mortensen & Dunn, 2001; Ösby, Correia, Brandt, Ekbom, et al., 2000). Use of alcohol and other drugs is often a complicating factor, especially in accidental deaths (Bossarte, Simon & Barker, 2006; Khalsa, Salvatore, Hennen, Baethge, et al., 2008). Moreover, rates of premature death from suicide and violent crime have been increasing compared to the general population since the 1970s. This same study also found that compared to the general population, both men and women with schizophrenia were eight times more likely to die prematurely (before age 56), highlighting the need for much closer follow up and better treatment for this population who are at substantially elevated risk of adverse outcomes (Fazel, Wolf, Palm, & Lichtenstein, 2014).

Suicide

For people with serious mental illness, the risk of suicide is 9 – 10 times greater than the risk for people in the general population (Harris & Barraclough, 1997; Harris & Barraclough, 1998). Several risk factors have been consistently identified. These include previous suicide attempt or previous attempts to harm oneself, presence of depressive symptoms, involvement with the police, and being a young male at time of inpatient admission,
People are most at risk immediately following discharge from the hospital, and within ninety days of discharge, especially for those discharged from a first admission (Appleby, Dennehy, Thomas, Faragher, et al., 1999; Lee & Lin, 2009) and the risk is greater for those without a previous admission during the year, compared to those hospitalized more than three times in the previous year (Geddes, & Juszczak, 1995; Goldacre, Seagroatt, Hawton, 1993; Heila, Isometsa, Henriksson, Heikkinen, et al., 1997; Lee & Lin, 2009).

Other than outreach and close follow up, few preventive measures have been identified, although high levels of support have been shown to reduce risk (Sinclair, Mullee, King & Baldwin, 2004).

Violence

People with serious mental illnesses are at increased of violence in the community (Brekke, Prindle, Bae & Long, 2001) and are exposed to high rates of interpersonal violence (Carmen, Rieker & Mills, 1984; Greenfield, Strakowski, Tohen, Batson, et al., 1994; Goodman, Salyers, Mueser, Rosenberg, et al., 2001; Lipschitz, Kaplan, Sorkenn, Faedda, et al., 1996; Mueser, Goodman, Trumbetta, Rosenberg, et al., 1998; Mueser, Salyers, Rosenberg, Goodman, et al., 2004). Those with mental illnesses are at much greater risk of homicide. Reasons for this include the fact that people with mental disorders are frequently very poor and often live in deprived areas with high crime rates, their symptoms may cause them to be less aware of risks to their own safety, and people with serious mental illnesses are often thought of as dangerous (Crump, Sundquist, Winkleby & Sundquist, 2013), potentially sparking attacks from others who are fearful.

People with serious mental illnesses are also sometimes perpetrators of aggression and violence, especially when they have not received treatment and are under the influence of alcohol and other drugs. The risk of retribution and increased fear and stress, can lead to the possibility of further escalating violence both to themselves and to others (Wehring & Carpenter, 2011). The risk of an individual committing a homicide is greater during the first episode of psychosis and for those who have not received treatment (Nielssen & Large, 2010). However, people with serious mental illnesses are much more often the victims of violence, with victimization of individuals with these illnesses found to be more than four times the incidence in the general US population (Choe, Teplin, & Abram, 2008; Teplin, McClelland, Abram & Weiner, 2005).

Engaging people in treatment as soon as symptoms are observed is highly important. Receiving timely medical treatment has consistently been found to reduce the risk that an individual will commit a homicide or suicide (Coid, 1983; Fazel & Grann, 2004; Meehan, Flynn, Hunt, et al., 2006; Nielssen, Westmore, Large & Hayes, 2007; Wallace, Mullen, Burgess, Palmer, et al., 1998). It has further been shown that the second-generation
antipsychotics clozapine, risperidone, and olanzapine significantly decreased violent behavior, while conventional antipsychotics did not have the same effect. (Swanson, Swartz & Elbogen, 2004). Unfortunately, there are often delays in accessing treatment for people experiencing their first episode of psychosis, putting them and others at risk.

In addition to psychotropic medication, a recovery oriented, person centered approach to engaging people to recognize their illness and take part in psychosocial rehabilitation interventions such as CBT, skills training, illness management, and family psychoeducation, are important for helping individuals with serious mental illnesses to gain control of their illness and their lives, identify the goals they wish to accomplish, and achieve a satisfying life.

Although there are many factors that influence functional outcomes, there is growing evidence that early intervention with pharmacologic and psychosocial interventions during the first episode of psychosis may lead to improved longterm outcomes (Bertelsen, Jeppesen, Petersen, Thorup, et al., 2008; Bird, Premkumar, Kendall, Whittington, et al., 2010; Ehmann, Yager & Hanson, 2008; Marshall & Rathbone, 2011; McGlashan, Evensen, Haahr, et al., 2011; Tandon, Keshavan & Nasrallah, 2008) and may prevent or delay relapse (Álvarez-Jiménez, Parker, Hetrick, McGorry, et al., 2011).

Risks for both suicide and violence are greater during the first episode of psychosis and for those who have not received treatment. Given that this appears to be a critical period for these events, greater awareness of the prodromal signs and their implications should be provided to general practitioners and the general public to encourage early intervention.

**Treatment Disparities for Racial and Ethnic Minorities**

Following publication of the Surgeon General’s 1999 Report (U.S. Department of Health and Human Services, 1999), it was recognized that disparities in mental health and physical health care are influenced by a variety of factors, including the race/ethnicity of the individual. As a result of this recognition, a Supplement to the Surgeon General’s report was published that looked specifically at culture, race and ethnicity (U.S. Department of Health and Human Services, 2001). This Supplement spawned an increase in research on, and publications about the impact of these mediating variables on mental health care in the U.S.

The Supplement summed the situation up concisely:

Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.... A major finding of this Supplement is that racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their over-all health and productivity (U.S. Department of Health and Human Services, 2001, p. 3).
Virtually every publication on this topic since the Supplement has concluded that substantial differences remain in the way that people from racial and ethnic minorities are treated compared to the way that people from non-minority groups are treated (Alexandre, Martins & Richard, 2009; Atdjian & Vega, 2005; Compton, Ramsay, Shim, Goulding, et al., 2009; Kilbourne, Switzer, Hyman, Crowley-Matoka, et al., 2006; Mallinger, Fisher, Brown & Lamberti, 2006; Rost, Hsieh, Xu, Menachemi, et al., 2011; Snowden, 2003; Whitley & Lawson, 2010; Williams & Mohammed, 2009).

The issues and findings are complex. Some studies have found differences for one group but not for another and at times the findings of one study conflict with the findings of another study. The findings are also complicated by the fact that there are differences in some physicians’ attitudes toward people from non-majority racial and ethnic backgrounds. Additionally, there are consumer differences related to factors such as a person’s willingness to seek treatment, interest in remaining in treatment, willingness and or ability to fill prescriptions, socioeconomic status and the multitude of factors that SES affects and that in turn affect SES, including availability of health insurance (Atdjian & Vega, 2005; Canadian Mental Health Association & Wellesley Institute, 2009; Graham, 2007; Veling, Selten, Susser, Laan, et al., 2007; Wilkinson & Pickett, 2009). All of these make presentation of a consistent pattern challenging.

Although there are many different racial and ethnic groups in North America, most of the literature is centered on African Americans and Hispanics. The most consistent findings relate to provision of treatment based on published guidelines, including appropriate prescribing practices, and provision of care in appropriate settings.

**Guideline Based Treatment**

Several studies have found that both African Americans and Hispanics are less likely to receive treatment that is based on established guidelines (Wang, Berglund, Kessler, 2001; Wang, Demler, Kessler, 2002; Whitley & Lawson, 2010; Young, Klap, Sherbourne & Wells, 2001). With respect to prescription of antipsychotic medication, ethnic minorities have been found consistently less likely than non-ethnic minorities to be treated with newer antipsychotic medications (Puyat, Daw, Cunningham, Law, Wong, Greyson & Morgan, 2013). One finding was quite consistent: African Americans often do not receive appropriate medications or the appropriate dose of a medication. Some studies indicate that African Americans are less likely to receive antipsychotic medication (Mallinger, Fisher, Brown & Lamberti, 2006), and some studies have indicated that when these medications are prescribed, the dosages are higher than they should be (Blazer, Hybels, Simonsick & Hanlon, 2000; Chung, Mahler & Kakuma, 1995; Kuno & Rothbard, 1997; Lawson, 1999; Melfi, Croghan, Segal, Bola & Watson, 2000; Sclar, Robinson, Skaer & Galin, 1999; Snowden & Pingatore, 2002; Walkup, McAlpine, Olfson, Labay, et al., 2000). Relatedly, some studies have found that African Americans are diagnosed more frequently with schizophrenia (although it has also been suggested that this could be due to the way symptoms are presented) and Hispanics are diagnosed more frequently with depression. It has also been
reported that African Americans often receive higher doses of antipsychotic medication while Hispanics often receive lower doses of these medications (Atdjian & Vega, 2005).

**Treatment Settings**

Another consistent finding is that African Americans are over-represented in non-forensic in-patient settings and in emergency room departments (Snowden, 1999). Both African Americans and Hispanics are over-represented in forensic psychiatric hospitals and in jails and prisons. As is widely recognized, these settings have become some of the largest treatment venues in the U.S. for people with serious mental illnesses (Lindsey & Paul, 1989; Rosenhan, 1984; Whitley & Lawson, 2010). These issues are discussed in detail in the Forensics modules of this curriculum.

**What are the Reasons for Disparities in Care?**

Many of the reasons for the disparities in care are similar whether one considers the differences between physical and mental illness or the differences between minority and non-minority groups. While the original Report of the Surgeon General (U.S. Health and Human Services, 1999) highlighted some of these reasons, the Supplement to the Report (U.S. Department of Health and Human Services, 2001) focused to a much greater extent on the reasons behind these disparities.

As pointed out by the Supplement to the Surgeon General’s Report, more is known about the disparities in treatment than the reasons behind those reasons. The Supplement proposed several likely reasons as follows:

The foremost barriers include the cost of care, societal stigma, and the fragmented organization of services. Additional barriers include clinicians’ lack of awareness of cultural issues, bias, or inability to speak the client’s language, and the client’s fear and mistrust of treatment. More broadly, disparities also stem from minorities’ historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status (U.S. Department of Health and Human Services, 2001, p 4).

Related to the reasons mentioned by the Surgeon General’s Supplement, several reasons have been proposed in the literature. These include lack of insurance, mis-communication or mis-perceptions of providers due to language or other cultural factors, bias of providers toward people with serious mental illnesses and those from minority racial and ethnic backgrounds, and challenges presented by the characteristics of the population itself.

**Lack of Insurance**

People with serious mental illnesses are most often poor, unemployed, and lack health insurance. Many people also are homeless or inadequately housed. If they are working, they may be earning so little that they fall just above the eligibility line for Medicaid, but without access to health insurance, making access to other than emergency health care
extremely difficult. Without access to health care, they may end up in emergency rooms or in jail when treatment is needed, and this can ultimately lead to a worsening of their mental health condition (Atdjian & Vega, 2005; Graham, 2007; Wilkinson & Pickett, 2009). Delays in receiving treatment due to lack of health insurance have also been reported for young people with emerging psychoses (Compton, Ramsay, Shim, Goulding, et al., 2009). As noted earlier in this module, delays in first episode treatment have been related to violence and homicide for this population, making early intervention an issue of considerable importance.

Cultural Factors

There can be many reasons for miscommunication. Many people in North America come from countries where English is not the first language and may not even be spoken. In addition to difficulties with language, there are many other ways that culture can have an impact on what is communicated. Some cultures do not acknowledge the existence of mental illnesses or acknowledge their existence only in certain circumstances. Within some cultures, there is great stigma associated with mental illness; for others, there are gender differences in acceptability of different illnesses (Alegria, Canino, Rios, Vera, et al., 2002; Kung, 2004; Leong & Lau, 2001). Mis-understanding due to translation problems is another potential difficulty (Baker, Hayes & Fortier, 1998; David & Rhee, 1998). Establishing trust can require overcoming reluctance and fear due to years of prior mis-treatment or prejudice (Akutsu, Snowden & Organista, 1996; Snowden, Hu & Jerrell, 1999; Takeuchi, Sue & Yeh, 1995; Yeh, Takeuchi & Sue, 1994).

Practitioner Bias

Practitioner bias such as holding beliefs and expectations about members of a certain group or population has been suggested as one of the major reasons why people with serious mental illnesses and people from racial and ethnic minorities receive sub-standard care (Ahn, Proctor & Flanagan, 2009; Atdjian & Vega, 2005; Osborne, 2001; Snowden, 2003). Most bias is subtle and often providers do not even recognize that they are biased (Burgess, van Ryn, Dovidio & Saha, 2007), but there is abundant evidence that physicians and other providers hold biases that impact their interpretation of presenting behaviors and symptoms, and that subsequently impact on the clinical judgments they make (Moy, Dayton & Clancy, 2005). Provider bias can be especially important when consumer characteristics such as poverty, reluctance to accept treatment, take medications, or “adhere” to recommendations are expressed (Mazi-Kotwal & Upadhyay, 2011; Snowden, 2003). One difficulty with overcoming bias is that practitioners are reluctant to admit that they are biased, even if they do realize it. Sensitivity and cultural competence training have been recommended but these have not always achieved the desired results (Burgess, van Ryn, Dovidio & Saha, 2007).
Challenges Presented by People with Serious Mental Illnesses

There are several challenges presented by people with serious mental illnesses. Individuals are often suspicious of mental health professionals (and often with good reason), and they may not want to have anything to do with the mental health system. The pervasive effects of stigma and the vulnerability of individuals who are ill can make it difficult for them to seek help (Mazi-Kotwal & Upadhyay, 2011; Thornicroft, 2011), or they may miss appointments or drop out of treatment (Atdjian & Vega, 2005). Individuals can sometimes present as hostile, fearful and uncooperative. These behaviors can reinforce a provider’s biases and make interactions highly charged and difficult. These factors can make it challenging for mental health providers to know how to be of assistance (Phelan, Stradins & Morrison, 2001). When racial and ethnic differences or language barriers are added, the result can be less than optimal and potentially damaging for the person who needs assistance, ultimately leading to the observed disparities in treatment.

Challenges

People with serious mental illnesses face many difficult challenges which can lead to the observed disparities in health care and early death rates seen in this population. The illnesses themselves present challenges that are daunting and in many cases, alter the course of the individual’s life. There are also challenges associated with the prescribed treatment and with the service delivery system and providers within those systems.

The challenges for psychologists and other mental health providers lie in helping people with serious mental illnesses benefit from smoking cessation and weight loss interventions. Encouragement is needed to help people connect the reasons for quitting smoking, losing weight, etc. to the achievement of their life goals. Despite the very real difficulties people with serious mental illness who want to avoid smoking and weight gain, some have achieved success.

Provision of person centered engagement, assessment and treatment planning is essential and must include a focus on the importance of lifestyle changes as a means for achieving the kinds of roles and lives that each person hopes to accomplish. Encouraging people and supporting them to remain in intervention programs despite the difficult impediments to success is crucial. Psychologists can also encourage their research colleagues to seek answers to overcome the physiologic inhibitors to smoking cessation and weight loss. Psychologists and other practitioners should challenge themselves and their colleagues to ensure that the most appropriate and up to date treatment is provided and to ensure that biases and prejudice are overcome. Psychologists and other practitioners should also work to change the systemic factors that contribute to failures of the mental health service system which allow these known health disparities to continue.
Summary

There are considerable disparities faced by people with physical health conditions and serious mental illnesses. On average, people who have a serious mental illness die twenty to twenty-five years earlier than those without such an illness. The reasons for this are complex and research continues to disentangle the effects of various contributing factors.

Smoking and obesity are among the most important factors but these are intertwined with the neurobiologic mechanisms of the disorders and the medications used to treat them. Although not fully understood, two of the most serious side effects of antipsychotic medications are the hypothesized therapeutic effects of smoking, and medication-induced weight gain. Both smoking and gaining weight have been shown to be highly resistant to change due to factors associated with the illness itself and the medications used to treat the illnesses.

There are additional issues faced by people from racial and ethnic minority backgrounds. Most of the available published literature centers on African Americans and Hispanics who have been shown to receive poorer quality treatment that is not based on published guidelines. Findings specific to treatment failures for minority persons include incorrect diagnoses, inappropriate medication dosing, and overuse of confinement in inpatient or forensic/jail settings.

In addition to the physiologic reasons that encourage smoking and weight gain, there are systemic reasons for the observed health disparities. The reasons range from personal and treatment system failures to issues presented by individuals with serious mental illnesses. Included are provider biases against people with serious mental illnesses and/or people from racial and ethnic minority backgrounds, failure to provide adequate and appropriate care due to cultural differences, poverty and lack of health insurance (in the U.S.), and delays in receiving treatment. Delays in receipt of treatment can be due to provider failures to recognize and offer appropriate treatment or due to individual and family delays because of previous negative experiences with the treatment system or lack of awareness and understanding of the illness and the need for intervention. Delays in treatment especially for the first episode of psychosis can be particularly problematic due to the heightened risk of suicide and violence for people with untreated psychoses.

Psychologists and other mental health providers need to strongly encourage people with serious mental illnesses to remain in smoking cessation and weight loss intervention programs despite the difficult impediments to success. Additionally, we need to challenge the personal and systemic factors that contribute to failures of the mental health service system that allow these known health disparities to continue. Finally, we need to encourage individuals to take charge of their health care and assist individuals to learn about and participate in wellness activities and practices.
Sample Learning Activity

There are two parts to this activity. The instructor(s) should take part in the exercise along with the students. The instructions for the second part of the activity are not to be given out until it is time to begin the second part.

General directions: The purpose of this role play is for students to understand the role that culture can play in a person’s interactions with the health care system and how those interactions may lead to incorrect or inappropriate diagnoses and treatment recommendations. Individuals can be misunderstood, dismissed, diagnosed incorrectly, etc. because in real life situations, time is often not taken to do things adequately. The person playing the consumer should respond as he or she believes a person would, i.e., if recovery oriented approaches are used, then the consumer might respond in kind, whereas if terse, medically oriented approaches are used, the person might feel misunderstood and respond accordingly. As little direction as possible should be given – the most important thing is that everyone should respond as genuinely as possible.

Part I: Depending on the size of the group, the large group is divided into two small groups. If the overall group is small, one group of 5 or 6 should be used. One or more volunteers will play the part of a person with a serious mental illness (one for each group). It is preferable if the volunteers actually know someone or has had experience with someone who has a serious mental illness so that their portrayal can be more genuine. If there is only one small group, the part of the young man below should be acted. If there are two small groups, one consumer actor will play the young man in the scenario below and the other consumer actor will play a young Hispanic woman, originally from Mexico. The details remain the same for both the young man and the young woman.

The consumer is a young black man, between 18 and 24 years old, originally from Somalia, who speaks with a heavy accent and who appears confused and “a bit out of it”. He has been using drugs to “take the away the pain in his head”. He has been living on the streets because he was thrown out of the last several places he was living due to his erratic behavior. He does not have contact with his family as he believes they are trying to kill him.

The person has been brought to the emergency room of the local hospital or clinic because he has been wandering around the streets late at night, talking to himself using obscenities and appearing to be angry and hostile.

Each of the non-consumer actors in the small group will play one of the following parts:

- The admitting nurse
- The evaluating psychologist
- The prescribing psychiatrist
- The peer support worker
The consumer actor should stay in the role to the greatest extent possible but should also follow his instincts about how to react to each of the other actors. Beginning with the nurse, each non-consumer actor will have a five minute conversation with the person and will formulate an opinion and recommendation that will be shared later. The finding is to contain the following elements:

a) initial diagnosis (recognizing that a real person centered interaction would take much longer than the time available in this role play), b) recommendation, and c) immediate plan of action

Part II: At the conclusion of the role play, all members of the group (or small group if divided) are to discuss the following (the following instructions should now be handed out to each participant):

1. What barriers to effective communication and participation in each of the consultations were there? What strategies were used to address these barriers? What other strategies could have been used?
2. What were the issues around capacity, decision making and consent in relation to this person?
3. How did the consumer actor feel during the interviewing process? Did he believe his concerns were genuinely heard?

The group should discuss each of the diagnoses, recommendations, and action plans that were offered. The consumer actor should indicate whether or not he felt that his true situation was recognized and whether or not the diagnosis, recommendation, and action plan of each of the actors will be helpful to someone in his situation.
### Sample Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Correct Answer</th>
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<tr>
<td>1. The primary causes of death for people with serious mental illnesses include:</td>
<td>b) cardiovascular diseases, respiratory diseases, and cancer&lt;br&gt;&lt;br&gt;f) b and c above&lt;br&gt;&lt;br&gt;f is correct</td>
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<tr>
<td>2. For African Americans in the mental health service delivery system, the following are true:</td>
<td>e) all of the above&lt;br&gt;&lt;br&gt;e is correct</td>
</tr>
<tr>
<td>3. Smoking cessation and weight loss programs save lives and have been shown to be highly effective for people with serious mental illnesses</td>
<td>F</td>
</tr>
<tr>
<td>4. People with serious mental illnesses are at greater risk of death from suicide and homicide during the initial stages of psychosis and when the illness is left untreated</td>
<td>T</td>
</tr>
<tr>
<td>5. People from racial and ethnic minority backgrounds have less access to care, receive poorer quality care, and suffer a greater loss to their overall health and productivity than do people from non minority backgrounds</td>
<td>T</td>
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</tbody>
</table>
Lecture Notes Citations


**Additional Resources**

American Psychological Association Recovery to Practice Initiative.  
http://www.apa.org/pi/rtp
Citing the Curriculum

Citation for this Module:

Citation for the full Curriculum:

For additional information, contact:
Recovery to Practice initiative at the American Psychological Association, [www.apa.org/pi/rtp](http://www.apa.org/pi/rtp)
or
Mary A. Jansen, Ph.D., at Bayview Behavioral Consulting, Inc., [mjansen@bayviewbehavioral.org](mailto:mjansen@bayviewbehavioral.org) or [jansenm@shaw.ca](mailto:jansenm@shaw.ca)