Innovative Directions to Advance Mental Health Disparities Research

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Disparities in mental health have persisted or worsened despite our awareness of their existence, increased understanding of their causes, and efforts at reduction and mitigation. Although much is known, there is still much to be done in mental health research to meaningfully impact disparities. In November 2020, the National Institute of Mental Health (NIMH) and the National Institute of Minority Health and Health Disparities (NIMHD) co-sponsored a virtual workshop to explore the complexities of mental health disparities, which revealed several gaps and opportunities for the field to pursue to advance mental health disparities research. This article, the introduction to a Special Issue on Mental Health Disparities, provides a frame for four articles that stem from and are inspired by the virtual NIMH/NIMHD workshop, all of which illustrate innovative research on understanding the complex mechanisms of disparities and how this knowledge can be translated into effective intervention development that advances mental health equity.

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Twenty years ago, the Surgeon General released *Mental Health: Culture, Race, and Ethnicity* (1), the seminal supplement to *Mental Health: A Report of the Surgeon General* (2). This report documented the existence of disparities for racial and ethnic minorities in mental health services and established the knowledge base to contextualize this pervasive health problem. Unfortunately, disparities in mental health and mental health care, defined here as differences in health outcomes that adversely affect disadvantaged populations (3), have persisted or worsened in the past two decades. Per legislation that created the National Institute on Minority Health and Health Disparities (NIMHD), populations that experience health disparities and social disadvantage include racially/ethnically minoritized individuals (the term "minoritized" is used in recognition that "minority" is a socially constructed term [4] and that systems place individuals into "minority" status [5]), populations of less privileged socioeconomic status, underserved rural populations, and sexual and gender minoritized individuals (3). Disparities continue despite our awareness of their existence, increased understanding of their causes, and efforts at reduction and mitigation.

DISPARITIES IN MENTAL HEALTH AND MENTAL HEALTH CARE

Disparities in mental health and mental health care are well documented and affect multiple populations across the lifespan. For example, compared to non-Hispanic White youths, Hispanic and Asian youths are more likely to be diagnosed with mood disorders. Black and Hispanic youths are more likely to be diagnosed with disruptive behavior disorders (6–8) and less likely to receive a diagnosis of attention deficit hyperactivity disorder (9, 10). Among adults, findings from community-based studies suggest that racial and ethnic minoritized adults have lower overall prevalence of mental disorders compared to White adults (11, 12), and adults living in rural areas have similar prevalences of most mental disorders compared to those living in urban areas (13). However, research suggests that once diagnosed, racial/ethnic minoritized adults are more likely have more severe and persistent courses of disorders than White adults (11, 14). These differences may be driven by sociocultural and systemic factors, including bias in diagnosis (15, 16), cultural differences in identification and manifestation of symptoms (17, 18), and differential access to mental health care (1). Mental health care disparities are especially pervasive and problematic, as they not only imperil the achievement of mental health equity, but they also contribute to a complex process that exacerbates existing disparities and disproportionalities in other health and social systems (e.g., in education systems, social services systems, and carceral systems), which in turn worsens disparities in the health and mental health system. Thus, mental health and mental health care disparities increase the burden of illness on individuals, families, communities, and society.

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There are also striking disparities in suicide and suicidal thoughts and behaviors. Suicide disproportionately affects American Indian/Alaska Native youths: between 2003 and 2014, American Indian/Alaska Native suicide rates were more than 3.5 times higher than among Blacks and Hispanics (19). The death rate from suicide remains significantly higher among American Indian/Alaska Native populations from late adolescence through adulthood (19, 20). More recently, rates of suicide and suicidal thoughts and behaviors increased markedly among Black and Asian youths (21–23). Factors beyond race are also associated with disparities in suicidality. Rates of death by suicide are higher among those living in rural areas compared to those living in urban areas (24), and the prevalence of suicidal thoughts and behaviors is higher among sexual and gender minoritized individuals than among cisgender heterosexual individuals (25, 26). In addition, recent analyses by Ramchand et al. (27) suggest differences in suicidal thoughts and behaviors between lesbian, gay, bisexual, and heterosexual adults by race/ethnicity, highlighting the importance of examining mental health disparities and outcomes across multiple social identities (e.g., race, gender, sexual orientation) that impact health.

Achieving mental health equity is not possible without addressing disparities in mental health care. Research suggests that despite higher rates of certain mental illnesses and suicide risk, racial and ethnic minoritized individuals are less likely than White individuals to receive adequate mental health care (2, 4, 6). For example, Black, Hispanic, and Asian youths utilize mental health services significantly less than White youths, and White youths are more likely to initiate treatment for all mental illnesses (28–30). When they do receive care, racial and ethnic minoritized youths are more likely to receive mental health care in emergency departments than in community-based, outpatient settings (31), a trend that appears to extend into adulthood (32). Among rural youths and adults, although the prevalence of most mental disorders is similar to that of urban individuals (13), individuals in rural areas are less likely to access and receive mental health care (33, 34).

These consistent findings highlight the broad range and reach of mental health and mental health care disparities and underscore the need to consider intersectionality. Intersectionality is a theoretical framework for understanding how individuals' multiple social identities and other demographic factors (e.g., birthplace, rurality, socioeconomic status) combine to form multiple interlocking systems of privilege and oppression (e.g., racism, sexism, heterosexism, and classism) (35). A term introduced by legal scholar Kimberlé Crenshaw, intersectionality was initially used to characterize the ways in which race, gender, and social class interact to shape Black women's experiences (36, 37). The conceptualization of intersectionality has since broadened to include the existence of multiple social identities and is recognized as critical to understanding how mental health disparities arise, persist, and impact individuals from multiple historically marginalized groups (35, 38). Given this recognition, the use of multilevel and structural approaches is essential to adequately address the complex nature of disparities. Community-level, society-level, or policy-level interventions, for example, that address social and structural factors (e.g., stigma, racism, and discrimination) and that impact multiple aspects of intersectionality are needed to address the persistence of such mental health disparities and have significant clinical and research implications. Failure to address intersectionality more comprehensively in research and clinical practice will significantly impair the field's ability to achieve equity.

UNDERSTANDING THE FACTORS LEADING TO MENTAL HEALTH DISPARITIES

While the existence and persistence of mental health and mental health care disparities are indisputable, there remains significant debate about the primary causes of these disparities (39). Historically, the focus has been on individual-level factors, especially individual behavior (health preferences, mental health literacy, provider shortages, limited cultural humility, etc.). While these factors may be relevant and explain some of the variation in disparities outcomes, a sole focus on individual-level factors ignores the critical role of social and structural factors that contribute to poor mental health outcomes that drive mental health disparities and ultimately exacerbate inequities.

The field has increasingly recognized the importance of social determinants of health and discrimination in a wide range of health and mental health outcomes and in mental health disparities (40). There has been extensive research documenting the impact of social determinants of health, or those "conditions in which people are born, grow, live, work, and age, which are shaped by the distribution of money, power, and resources" (41, p. 1). Determinants such as food insecurity (42), adverse childhood experiences (43), adverse features of the built environment (44), and racism and discrimination (45) are among those most frequently found to correlate with and confer mental health risk. Minoritized individuals are more likely to experience multiple forms of racism and discrimination, experience poor environmental conditions, reside in segregated communities, and encounter provider bias in treatment compared to White individuals (46). And while the field has long acknowledged the impact of race and discrimination on minoritized individuals' mental health in disparities research (e.g., 47–49), the emergence of the COVID-19 pandemic, the recent episodes of police violence and killings of unarmed Black men and women, and increased violent attacks and mass murder against specific racial and ethnic groups have highlighted the significance of these determinants in the context of disparities research.

FOSTERING RESEARCH TO REDUCE MENTAL HEALTH DISPARITIES

While the increased recognition of social determinants of health as significant drivers of mental health disparities is an important step, there is much to be done in mental health

research to meaningfully impact disparities and promote mental health equity. In November 2020, as a part of institutional efforts to understand and address challenges in fostering mental health disparities research, the National Institute of Mental Health (NIMH) and the NIMHD co-sponsored a virtual workshop to explore the complexities of mental health disparities. Although issues concerning improved funding of a diverse biomedical workforce and workforce diversity challenges are related to fostering mental health disparities research, which the NIH and its institutes and centers are addressing via multiple initiatives (50), these are not the focus of the present article. During the virtual workshop, leading researchers discussed multidimensional innovations in research and intervention development and implementation that are needed to address these disparities more effectively. Key themes from the workshop included the recognition that the field needs to improve our understanding of how to better implement effective treatments for minoritized populations, such as interventions that are culturally tailored and personally relevant (51, 52), or those that reduce disparities by improving quality of care (53, 54) and implementing a collaborative care model (55). Doing so requires improved understanding of the multifaceted mechanisms of mental illnesses in diverse populations as well as the mechanisms that underlie disparities in mental health.

Adding to the complexity of understanding drivers of mental health disparities is the fact that social determinants of health and a host of other factors can act interactively to drive mental health disparities. Studies aimed at understanding or intervening to reduce disparities should address this complexity. The National Institute on Minority Health and Health Disparities Research Framework provides guidance on identifying and studying factors relevant to understanding disparities. Examples of factors specifically relevant for mental health include biological vulnerability and mechanisms, health behaviors, family functioning, community environment, discrimination and response to discrimination, insurance coverage, availability of services, and quality of care. These examples span the framework's levels of influence and domains of influence, which further illustrate the multilevel, multidimensional approach required to conceptualize, measure, and address disparities.

This approach requires careful measurement of risk and protective factors and multilevel outcomes to fully characterize the complexity of mental health and health care disparities. For example, Hatzenbuehler and Link (56) have documented the significant mechanistic effects of structural stigma on disparities in mental health outcomes among LGBTQ youths and adults, but also note that additional research is needed to examine intersectionality and improve measurement of this complex construct (57–59). Thus, in developing complete models of mental health and health care disparities, researchers are encouraged to consider developing or building on existing measures of community-, social-, and structural-level factors that can be used in their work to examine multilevel risk and protective factors to advance our understanding of the mechanisms and interventions to reduce disparities.

In addition to developing better measures that are both culturally relevant and psychometrically appropriate, there is also a need to develop and study culturally and linguistically relevant interventions that target risk and protective mechanisms. For groups that are and have been underrepresented in mental health research, there remain opportunities to understand both the degree and experiences of mental health and health disparities within these populations, as well as risk and protective factors and intervention mechanisms. Accordingly, research that establishes the mechanisms by which mental health disparities arise and targets these mechanisms with interventions will be crucial to advancing innovative and impactful solutions to mental health disparities.

CONCLUSIONS

The articles in this issue stem from and are inspired by the November 2020 virtual NIMH/NIMHD workshop. They provide examples of research that echo the critical focus of the workshop on understanding the complex mechanisms of disparities and how to translate this understanding into effective intervention development that advances mental health equity. The first two articles describe the importance of building on and adopting multilevel, multidimensional perspectives in research and clinical practice to reduce mental health disparities. Alegría et al. ("A New Agenda for Optimizing Investments in Community Mental Health and Reducing Disparities") (60) offer a conceptual overview of an innovative public health approach that centers the community as the core of partnership, research, intervention, and policy development. Alvidrez and Barksdale ("Perspectives From the National Institutes of Health on Multidimensional Mental Health Disparities Research: A Framework for Advancing the Field") (61) describe an adaptation of the NIMHD Research Framework specific to mental health in their commentary and provide perspectives on how such an adapted framework may be used to advance multilevel mental health disparities research inquiry.

The other two articles focus on mechanistically examining structural racism within socially and developmentally salient contexts and how this determinant exacerbates mental health and health care disparities. The emphasis on acknowledging and examining the role of structural racism in disparities in these articles is especially timely and represents the innovative evolution in mental health disparities research both discussed during the virtual workshop and recommended by several scholars in field (62–64). Alvarez et al. ("Structural Racism and Suicide Prevention for Ethnoracially Minoritized Youth: A Conceptual Framework and Illustration Across Systems") (65) explore structural racism and its impact specifically within the developmental and cultural context of Hispanic youth suicide prevention and intervention. Hankerson et al. ("The Intergenerational Impact of Structural Racism and Cumulative Trauma on Depression") (66) explore the impact of structural racism and trauma on the

intergenerational transmission of depression and depression risk among racially and ethnically diverse individuals.

As a whole, the articles in this issue capture the evolving, yet overdue, shift in mental health and the broader biomedical research fields that acknowledges the role of social and structural determinants of health (particularly structural racism and discrimination) in the cause and perpetuation of disparities and inequities and the goal to adopt multilevel, structural intervention and research approaches to achieve desired mental health and health care disparities reductions.

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