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Centering Culture in Mental Health: Differences in Diagnosis, Treatment, and Access to Care Among Older People of Color

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Abstract

Mental healthcare disparities are routinely documented, yet they remain wider than in most other areas of healthcare services and common mental disorders (depression and anxiety) continue to be one of the highest health burdens for older people of color. To address disparities in mental health services for older people of color, the narrative must move beyond simply documenting these inequities and attain a better understanding of the internalized, interpersonal, systemic, and medical racism that have harmed these communities and excluded them from its services in the first place. It is imperative that researchers, clinicians, and policymakers acknowledge the realities of racism and discrimination as leading causes of mental healthcare disparities. Therefore, this review is a call-to-action. Authors adopt an antiracist and health equity lens in evaluating the differing needs of Blacks/African-Americans, Asian Americans, and Latinos by exploring psychiatric comorbidity, experiences with seeking, accessing, and engaging in treatment, and the

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unique cultural and psychosocial factors that affect treatment outcomes for these diverse groups. Further, authors offer researchers and practitioners tangible tools for developing and implementing culturally-sensitive, mental health focused interventions for older people of color with special attention placed on cultural adaptations, models of care, prevention, and practical strategies that can be implemented to reduce disparities and increase equity in mental healthcare.

Keywords

Older people of color; Disparities; Late life mental health; Stigma; Health beliefs; Prevention

INTRODUCTION

In 2003, the Institute of Medicine (IOM) published *Unequal Treatment*, which elevated racial and ethnic healthcare disparities to the forefront of clinical and policy attention.[1] However, since its publication, little progress has been made to lessen the disparities in mental healthcare, especially among older adults of color.[2–6] Despite routine documentation, racial and ethnic disparities in mental healthcare remain poorly explained. If we are to eliminate these disparities, then we must acknowledge the root and persistent cause of mental health inequities: racism. In this article, we offer a historical perspective on racism illustrating how it has impacted the mental health of older people of color and discuss psychiatric comorbidity, experiences with treatment, service utilization, and health beliefs from the perspectives of Blacks/African Americans, Asian Americans, and Latinos. Finally, we conclude with a discussion on what can be done to overcome the negative impacts of racism and meet the mental health needs of these communities with a focus on cultural adaptations, models of care, prevention, and practical strategies that can be implemented to reduce disparities and increase equity in mental healthcare. Since the effects of racism and its impact on diagnosis, treatment, and access to mental healthcare are ongoing, this review serves as a call to action rather than solely a review of the literature.

HISTORICAL PERSPECTIVE ON RACISM

Racism – defined as a multidimensional construct that involves the oppression, domination, and denigration of individuals by other individuals and social institutions based on skin color and/or membership in a particular ethnic group – has had a profound and negative impact on communities of color.[7] It often leads to negative attitudes and beliefs directed against an ethnic or racial group (prejudice), and differential treatment of members of these groups (discrimination). Racism can occur at multiple levels: internalized (incorporation of racist attitudes or beliefs into one's worldview), interpersonal (interactions between individuals), and systemic (laws and regulations of a society or an organization that disadvantages one or more racial or ethnic groups).[8–10] The impact is pervasive, deeply embedded in society, and places older people of color at greater risk for poor mental health outcomes through the creation and exacerbation of socioeconomic inequities (e.g., housing, education, wealth, and employment).[11–13]

The negative effects of racism are vast. Racism is associated with increased depression, anxiety, and psychological distress because it is an undeniably negative, demeaning, and

threatening reaction to an immutable personal characteristic.[12–18] Racism acts at many different levels with stigmatized groups internalizing the dominant society's ideology about their biological and/or cultural inferiority, and interpersonally as older people of color perceive more daily discrimination than their White peers.[15,16] Furthermore, systemic level factors such as redlining, transportation issues, language barriers, and financial obstacles impact contribute to persistent disparities in the utilization of appropriate mental healthcare services among older people of color.[19] For example, residential racial segregation is widely regarded as a primary institutional mechanism of racism and a fundamental cause of racial disparities in mental healthcare.[20–22] It leads to differences in neighborhood quality and community conditions; produces concentrations of poverty, social disorder, and social isolation; creates pathogenic conditions in residential environments; adversely affects access to quality mental health; and is a neglected but enduring legacy of institutional racism in the U.S.[20–22]

To address disparities in mental health services for older people of color, the narrative must move beyond simply addressing inadequate access to services to also validating that much of the stigma and mistrust minoritized communities hold towards the mental healthcare system is linked to a unique and troubling history of racism in medicine. For instance, stigma associated with mental health disorders is consistently identified as one of the most salient deterrents to mental health service utilization with individuals choosing not to not initiate or prematurely drop out of treatment to avoid the resulting consequences of bearing a mental illness label.[23] In addition to affecting service utilization, experiences of stigma can negatively impact individuals' social functioning, self-esteem, psychological health, physical health, and overall functioning.[24]

The stigma of mental illness has been identified as the most fundamental reason why older adults choose not to seek mental health treatment.[25] Stigma may have a particularly negative impact on the mental health experiences of Black, Latino, and Asian American older adults. Research has consistently found that communities of color have more stigmatized attitudes towards mental health disorders than White communities, often stemming from historical and culturally based representations of mental health disorders as a sign of personal weakness.[26,27] These representations can lead to embarrassment and shame, for the individual as well as for their family, particularly in cultures which place a strong emphasis on saving face and familial honor.[28] Moreover, older people of color living with mental health disorders face intersectional stigma stemming from their experience living with multiple identities that are stigmatized within a society.[29] The intensity of their experience with the stigma of mental illness may be heightened due to the pre-existing social inequities and stigma associated with older age and a person of color.[30] The impact of experiencing multiple stigmas concurrently may further impede assertive diagnosis and treatment.[31–33]

Further contributing to inequities in mental healthcare is medical racism, which has laid the foundation for minoritized communities to mistrust psychiatry. In American psychiatry, diagnostic criteria, questionnaires, and treatment practices were normed on the exclusive perceptions and values and expressions of White, cisgender, heterosexual, ableist men to serve the needs of other privileged, White groups.[34] Psychiatry has a long history of pathologizing cultural and racial differences that deviate from norms accepted

by White American mainstream culture.[34,35] This is best observed in the overdiagnosis of schizophrenia and underdiagnosis of affective disorders among African Americans, Afro-Caribbeans, and Latinos due clinician prejudice and lack of contextual diagnostic analysis.[35–42]

To destigmatize attitudes related to mental health disorders and improve access to mental healthcare among older adults of color, a greater emphasis must be placed on issues related to diversity, equity, and inclusion. It is imperative that researchers, clinicians, and policymakers acknowledge the realities of racism and discrimination as leading causes of mental healthcare disparities. These efforts will only be successful when clinical and policy level initiatives work collaboratively across disciplines to create, implement, and evaluate culturally-tailored interventions that acknowledge the diverse needs of these marginalized populations.

BLACK/AFRICAN AMERICAN EXPERIENCE

African Americans (also called Blacks in this paper) are an ethnic group in the U.S. with partial or total ancestry from any of the Black racial groups on the continent of Africa. The term African Americans generally denotes descendants of enslaved Africans who were brought to the U.S. However, in the U.S. the term African American includes immigrants from the Caribbean and from Africa, or anyone with phenotypically Black features. Therefore, the commonly held notion that African Americans are a homogeneous group of people with similar cultures, values, and experiences is damaging and inaccurate.

Centuries of enduring systemic racism have caused African Americans to be the poorest ethnic group in the U.S., as evidence by having the lowest household income in the U.S. for the last 50 years.[27,43] Poverty, which is known to be a result of employment and educational discrimination, highly correlates with poor mental health outcomes and increased morbidity and mortality.[43] This multilevel discrimination concentrates African Americans amongst groups with not only a high exposure to factors that increase risk for poor mental health (e.g., trauma, violence, discrimination etc.), but also reduced access to care (e.g., incarcerated, child welfare involvement, homeless etc.) despite a greater need.[43] Even with greater risk and higher levels of emotional distress, prevalence and incidence rates for most mental health disorders are similar for older Blacks and Whites, highlighting the protective factors (e.g., familial support, religion/spirituality, and peer and social support networks) contributing to resiliency among this population.

Psychiatric Comorbidity

A wealth of knowledge regarding prevalence and service use related to mental disorders among persons of African descent derives from the National Survey on American Life (NSAL)[44,45] which enrolled thousands of men and women who are African American and Afro-Caribbean. In the first study of its kind, which estimated lifetime and 12-month prevalence of 13 psychiatric disorders among older African American participants, Ford et al.[46] reported high burden of psychiatric disorders with lifetime and past-year prevalence rates of nearly 23% and 9%, respectively. Older Whites had significantly higher lifetime prevalence of depression and anxiety than African Americans, but 12-month rates were

similar across the two groups. In addition, African Americans are more likely than Whites to report frequent mental distress; are at greater risk of having poorer health-related quality of life; and have higher chronicity of depression and levels of disability attributable to depression.[43,47,48]

Measurement limitations contribute to challenges in assessing psychiatric symptoms and disorders among Blacks. For example, differential item functioning (DIF) – or item bias – may influence assessment of mental health among Blacks, and current methods or instruments may not apply adequately to the experiences of Blacks causing potential misclassification.[49] Such misclassification can lead to systematic over- or under-diagnosis of psychiatric disorders. Specifically, it has been noted as a "paradox" that population-based studies using Diagnostic and Statistical Manual (DSM) criteria have shown lower rates of depression among Blacks compared to Whites; yet, epidemiologic cohort studies have tended to report higher levels of psychological distress and depressive symptoms among Blacks.[48] For example, in a large study of over 3,000 Black and White older adults over a 10-year period, Barry et al.[50] observed that the burden of depressive symptoms was higher and remained higher among Blacks compared to Whites.

A potential explanation for the apparent paradox is that the very construction of diagnostic algorithms used for criteria-based depression diagnoses may systematically misclassify Black participants, if their expressions of symptoms do not match the algorithm's construction.[48] For example, older African Americans are more likely to express irritability, social isolation, loneliness, and loss of control rather than stating that they are depressed or anxious.[51] In addition, attempts to share the realities of racism and mistrust in their lives risk being misinterpreted as pathological paranoia or psychosis.[42] Alternatively, dimensional measures of distress may be less affected by this potential source of bias, especially if there is sufficient coverage of symptom expressions that are more relevant to Blacks. The second possible explanation is that those without a mental disorder are more likely to live to older ages (i.e., selection effect).[46] As a result, older individuals tend to have a lower prevalence of psychiatric disorders because this is a healthier population.

Experiences With Treatment and Service Utilization

Disparities in mental health treatment and service utilization have been consistently observed for Blacks.[6,52–54] Specifically, data indicate mismatches in rates of treatment and service use with respect to the burden of symptoms and severity among Blacks. Using data from the nationally representative Medical Expenditure Panel Survey (MEPS), Han and Liu[52] found that Blacks with a range of different mental illnesses (i.e., affective, anxiety, psychotic, substance-related, etc.) are significantly less likely to be using prescription medications for these mental illnesses than Whites. Similarly, Gaskin et al.[53] found that among a nationally representative sample of Medicare beneficiaries, a large share of the disparity among Black compared to White patients' prescription drug utilization was attributable to race/ethnicity and not adequately explained by other factors. Overall, underutilization of mental health services among Blacks is substantial with service usage as low as 32% among those who clearly met DSM criteria for mental illness in the past 12-months, and 49% among those with serious mental illness (SMI).[54]

Structural inequalities as well as cultural values may influence treatment and service utilization. African Americans are more likely to be uninsured, may have preferences for other treatments (e.g., group therapy, psychosocial interventions), or may lack access to care providers who can provide culturally-informed or culturally-relevant care.[32,33,52–54] These findings point to the importance of providing mental healthcare in settings and using approaches that are culturally relevant, appropriate and accessible to Black older adults. Nevertheless, data from Hall and colleagues[55] show that, when provided equal access to traditional pharmacology and therapy treatments, older Black adults have comparable adherence and responses to treatment. Among participants receiving antidepressant and supportive care during the initial phase of this randomized trial, Black older adults compared to White older adults with comparable depression severity at baseline had higher comorbidity and worse health at baseline and were less likely to have received an adequate trial of antidepressants or therapy before beginning the study. Following treatment, Blacks had similar remission rates and were no more likely to experience side effects or discontinue antidepressants.[55]

Health Beliefs

Cultural values contribute to the mental health of older Black adults in complex ways. A strong social network is believed to be a protective factor against mental health problems, and many older Blacks look to intergenerational family support for help in a time of need.[26] In addition, positive influences of beliefs, such as optimism, may promote resilience and lower depression risk among Blacks.[56] The consequences of living in poverty for many older African Americans is reflected in their belief that stress over money is a cause of mental illness.[26] Unique experiences of racism and discrimination (e.g., Tuskegee, segregation, Jim Crow etc.) in the history of African-descended persons, may contribute to current race-based stressors (e.g., murder of George Floyd, etc.) that negatively affect the mental health of older Blacks. Among older Blacks, racial discrimination is associated with overall worse mental health: significantly higher odds of any psychiatric disorder, more lifetime DSM-IV disorders, and elevated levels of depressive symptoms and psychological distress.[12]

Overall, these findings shed light on a glaring gap in our service delivery system - culturally competent mental healthcare for older Blacks. Research suggests that most clinicians have patients who have been exposed to race-based trauma, yet almost none of these clinicians were trained to assess for or treat race-based trauma in their academic or workplace setting.[57] This disconnect can create significant challenges for older Blacks who need culturally responsive care to deal with their exposure to racism, which can trigger or exacerbate other mental health symptoms, yet cannot find such care and either do not get needed treatment or get culturally unresponsive/insensitive care that further traumatizes the patient. Furthermore, attribution beliefs of race bias may modify the relationship between experiences of discrimination and odds of having major depression depending on the intersections of race, ethnicity, and gender.[58] Thus, additional work is needed to understand how experiences of racial bias and/or discrimination, as well as beliefs regarding health state attribution related to those experiences, may influence depression risk, treatment, and treatment responses among Blacks.

ASIAN AMERICAN EXPERIENCE

The notion that there is a single, unifying "Asian community" is incorrect. Asian Americans comprise at least 43 heterogeneous communities with distinctive languages, religions, and socio-cultural heritages. No single country-of-origin group dominates the U.S. Asian population, but the largest groups are of Chinese, Indian, Filipino, Vietnamese, and Korean origin. Although many older Asian Americans are foreign born and are relatively recent immigrants, immigration history varies among ethnic subgroups. For example, 27% of Japanese Americans are immigrants while 78% of Burmese Americans are foreign born.[59]

Asian Americans have been unfairly portrayed as a population with high education and middle-class earning potential. This "model minority" myth refers to such a misconception that Asian Americans are well adjusted and thriving in the U.S.[60] This stereotype overlooks the heterogeneity within the Asian American community in terms of psychosocial needs and, as a consequence, older Asian Americans are frequently overlooked in national conversations on poverty and mental health needs. In fact, older Asian Americans are often faring worse economically compared with the general older White population.[61] Poverty, social isolation, limited English proficiency, and inadequate community outreach keep vulnerable older Asian Americans from accessing social and mental health services. On the other hand, strong familial support, religion/spirituality, and peer and social support networks are major strengths, which contribute to the resilience exhibited by older Asian Americans.

Psychiatric Morbidity

Nationally representative epidemiological data for mental health issues among older Asian Americans are sparse and are rarely broken down by subgroups if available at all. Moreover, the available disaggregated data are mainly focused on the largest subgroups (e.g., Chinese and Filipinos), making it difficult to capture meaningful variations across diverse ethnic subgroups. Existing studies using aggregated data suggest that older Asian Americans experience a similar or a lower rate of mental health issues as compared to Whites.[62–64] According to the data from National Latino and Asian American Study (NLAAS), one of the first representative epidemiological surveys of psychiatric morbidities of the U.S, the most common lifetime mental health issues among older Asian Americans are depression (6.7%) and anxiety (9.4%).[63] Older Asian Americans experience lifetime prevalence of 14.6% and 12-month prevalence of 7.8% for any mental disorder;[63] however, data suggest that there may be greater variations in psychiatric morbidity across various Asian American subgroups. For example, prevalence of depression has been found to be 44.8% in older Korean Americans[64] compared to 20% in older Japanese Americans.[65] In another study, older Vietnamese Americans experienced higher rates of major depression compared to their Chinese and Filipino counterparts.[66]

Cultural and linguistic factors may be affecting the reported rates of psychiatric illness for older Asian Americans who tend to report symptoms in physical or psychosomatic terms, such as loss of sleep and fatigue.[67] Chinese respondents are more reluctant to report psychological distress, are more likely to somaticize, and tend to describe depressive symptoms differently when compared to Whites.[68–70] Chang and colleagues[71] found that

symptom patterns and forms of depression in Korea, as defined by the DSM framework, are not identical to those in the U.S. Hmong older adults do not recognize depression as a mental health problem, and in the Hmong language, there is no direct translation of or definition for the term, "depression."[72] Therefore, the way Asian Americans express their mental illness may not be captured in instruments designed for White populations within the U.S.

Pre-migration experience is highly associated with depression and anxiety in the older Asian immigrant population. For many older Southeast Asian refugees, the impact of pre-migration experiences persists years after they resettle in the U.S.[73] One study found that 70% of Southeast Asian refugees - the majority Cambodian, Hmong, and Mien - receiving mental healthcare were diagnosed with PTSD.[73] Post migration, stressors related to adjustment and acculturation such as language barriers, unfair treatment by others, worries about legal status, and lack of social ties are often experienced and are associated with poor physical and mental health conditions.[74–78] Data suggest that the decline in health may also be explained as the increased socioemotional burden of racial discrimination from one generation to the next. For example, Asian immigrants who arrived before the age of 25-years reported more discrimination than those who arrived at older ages, despite having better English proficiency.[79]

Suicide remains a serious public health concern for older Asian Americans. Research finds that a considerably higher proportion of older Asian Americans (56.8%) endorse suicidal or death ideation than older African Americans (27.0%) leading to alarmingly high rates of death by suicide for this population.[80] Older Asian American females suffer from the highest suicide rate compared to females from all other racial backgrounds with approximately 6.57 per 100,000 Asian American women aged 85 and over completing suicides compared to 3.27 per 100,000 among their White counterparts.[80] Suicide rates in Asian American men reach their peak in old age; in contrast to Latinos and African American men, where the rates decrease with age.[80] In addition to known risk factors for suicide in the general population (e.g., social isolation, loneliness, and financial hardship); a multitude of acculturative stressors such as language and cultural barriers and discrimination, were found to be associated with suicidal ideation and attempts in older Asian Americans.[81]

Experiences With Treatment and Service Utilization

Mental health treatment disparities among Asian Americans of all age groups are stark. Asian Americans are between two and five times less likely to receive mental health services than their White peers, even after controlling for prevalence of mental health disorders.[6,81,82] Several cultural barriers to mental healthcare for older Asian Americans have been identified. At the individual level, internalized stigma against mental health problems, lack of English proficiency, and lack of knowledge about community resources may prevent many Asian American older adults from seeking beneficial care.[83] The strong emphasis on filial responsibility, family cohesion, and harmony over individual happiness shapes family caregiving practices among modern Asian Americans with a significant cultural pressure to care for ill family members within the family prevailing in Asian American communities.[84]

Due to negative connotations associated with institutionalizing family members who are chronically ill, Asian Americans are reluctant to hospitalize a family member with mental illness even if the clinical conditions warrant it.[84,85] Additionally, there is a lack of cultural competence and bias among mental healthcare professionals with nearly 13% of Asian Americans reporting experiencing discrimination during a health clinic visit.[85] Finally, the model minority stereotype contributes to myths about the lack of social and mental health problems among Asian Americans. Consequently, inadequate resources have been allocated to develop culturally appropriate mental healthcare programs for this population.

Health Beliefs

Cultural perceptions of mental health disorders influence symptom manifestations and responses to the illness.[72,82] In general, older Asian Americans hold a holistic view of health in which the mind-body dichotomy does not exist, and that finding balance is the key to successful health. Consequently, older Asian Americans may not accept the Western medical model of mental illness, which conceptualizes these conditions as brain diseases requiring professional treatments. In comparison to Whites, a greater proportion of older Asian Americans believed that non-biological factors (e.g., family issues, medical illness, and cultural differences) cause mental illness.[26] Such health beliefs impact when, where, and whom older Asian Americans seek help from for their mental health issues. Older Asian Americans prefer to seek help from a traditional healer or complementary therapies rather than western mental health professionals and may also favor informal solutions for their mental health problems (e.g., seeking the support of friends or family or working out problems on their own).[84,85]

THE LATINO EXPERIENCE

The U.S. Census Bureau defines Latino as an ethnicity composed of individuals of Cuban, Dominican, Mexican, Puerto Rican, South American, Central American, or other Spanish culture or origin regardless of race.[86] Although the majority of U.S. Latinos are of Mexican origin (37.2 million or 61.5% of the total US Latino population in 2019), Latinos from Puerto Rico, Cuba, the Dominican Republic, and Central and South America account for a substantial proportion of Latinos living in the Eastern and Southern regions of the U.S.[87] Despite this heterogeneity, national studies focusing on older Latino mental health often combine Latino subgroups into one, uniform group. Scientifically, this is done to have adequately powered studies. Culturally, there is some justification as there are many shared characteristics and values such as language, familism, and religiosity.[88] However, despite sharing a common label, each Latino subgroup faces unique difficulties regarding their immigration patterns and acculturation processes in the U.S. that differentially impacts their mental health.[89]

Psychiatric Morbidity

Depression and anxiety are prevalent among older Latinos. Using the combined data from the three nationally representative studies included as part of the NIMH Collaborative Psychiatric Epidemiological Surveys (CPES), Jimenez and colleagues[5] found that Latinos and Whites had similar lifetime prevalence of any depressive disorder (16.4% versus 12.2%)

and of any anxiety disorder (15.3% versus 13.5%). Although no differences were seen in any anxiety disorder (9.4% versus 8.4%) between Latinos and Whites, significantly higher 12-month prevalence of any depressive disorder (8.0% versus 3.2%) and major depressive episodes (7.3% versus 2.9%) were observed.[5] This is consistent with data suggesting older Latinos demonstrate higher rates of depressive symptoms and report a greater level of chronic stress compared to Whites.[90,91]

The burden of mental illness is quite high among older Latinos as a whole; however, this burden may not be equally shared among various Latino ethnic subgroups. Using the Health and Retirement Study dataset, Yang, Cazorla-Lancaster, and Jones[92] examined the prevalence of major depression in different groups of Latino older adults. They found that Puerto Ricans had the highest prevalence of major depression (19.3%), Mexican Americans had the lowest (8.2%), and Cuban Americans were in the middle (11.7%). González et al.[63] used the CPES dataset and found similar results: Puerto Ricans had the highest 12-month and lifetime prevalence of major depression (10.2%, 18.4%), Mexican Americans had the lowest (4.6%, 9.0%), and Cuban Americans were in the middle (5.5%, 14.8%).

Country of origin alone does not confer risk or protection from psychiatric illness. Rather, it is a complex combination of familial, contextual, and social factors associated with nativity, and age of arrival in the U.S. that can protect or place older Latinos at risk.[89] Other factors such as sex, gender, acculturation, language use, and geographical region of residence in the U.S. should also be considered in understanding how mental health determinants among older Latinos may affect the development and implementation of intervention approaches. In addition, studies suggest that immigrant health advantages earlier in life may yield over time to the cumulative adversity of homeland estrangement, social isolation, and the overwhelming effects of socioeconomic disadvantages in later years when older immigrant Latinos may lack the language and cultural fluency necessary to access barriers to quality mental healthcare that could relieve anxiety and depression.[5,63,89]

Experiences With Treatment and Service Utilization

Older Latinos do not seek mental health services at the same rate as their White counterparts. A study measuring mental healthcare utilization among older Latinos and Whites across the U.S. showed that only 24% of Latinos compared to nearly 35% of Whites initiated mental health treatment when they need it.[6] Furthermore, even when older Latinos seek treatment; they are less likely to receive adequate mental healthcare and tend to drop out of treatment two to three times more frequently than Whites.[6,93]

Limited English proficiency (LEP) is a significant barrier to mental healthcare, especially for older Latinos as approximately 40% speak English “not well” or “not at all.”[94] A comprehensive psychiatric evaluation hinges on obtaining a thorough history and elucidation of clear, accurate descriptions of symptoms. Therefore, language barriers can prevent recognizing and labeling mental health problems which may interfere with successful communication about treatment needs and care options.[95] Often, persons with LEP receive either ineffective or inadequate mental healthcare or drop out of treatment prematurely.[95] Previous research indicates that Latino adults with LEP are less likely to utilize mental health services, when compared to their peers who were proficient or fluent in English.[95]

In addition, a qualitative study by Patel, Firmender, and Snowden[96] found that the single factor that contributed most to LEP individuals' use of mental health services was access to providers who spoke their native languages. Taken together, these results suggest that language plays a critical role in the gaps in treatment seeking behavior.

An important gap that has been identified in a culturally appropriate approach to mental health among older Latinos is the underrepresentation of idioms of distress.[97] Extensive literature has recognized that Latinos express mental health distress (i.e., anxiety and depression) by way of somatization (pain, headaches, fatigue, gastrointestinal distress) rather than by more traditional symptoms (e.g., sadness, loss of interest).[98,99] This may explain in part why older Latinos are less likely to be screened, diagnosed, and treated for depression and anxiety than their White counterparts.[100–102] For example, a qualitative study comparing idioms of distress between older Latinos and older Whites found that Latinos more frequently use terms not included in traditional diagnostic tools such as "general malaise" and "pain" (physical and emotional) than their White counterparts to refer to mental health distress.[102]

Health Beliefs

Cultural values influence beliefs on the causes of mental illness that ultimately shape the type of care pursued and treatment preferences, which can explain in part healthcare disparities among Latinos.[26] Older Latinos have expressed the belief that mental illness is caused by a variety of issues including loss of family and friends, family issues, and moving to a different place. The disruption of the social support network by immigration to the U.S. is believed to be traumatic and can lead to poor health.[26] The potential consequences might be a detrimental loss of belonging and social isolation. Other overarching themes generally cited on the causes of mental illness by Latinos include having a weak character, supernatural beliefs (e.g., punishment from God), and normal aging.[31]

WHAT CAN BE DONE?

In the previous sections, we illustrated the role of racism and discrimination as the leading causes of mental healthcare disparities and how older people of color have coped with the realities of racism. We now provide recommendations on what can be done to address the unique mental health needs of these communities with a focus on cultural adaptations, models of care, prevention, and practical strategies that can be implemented to increase equity in mental healthcare. Table 1 summarizes the most salient differences between Blacks/African Americans, Asian Americans, Latinos, and Whites and their relevance for the design of interventions.

Cultural Adaptations

Cultural adaptation of mental health programs involves making systematic changes to evidence-based interventions to incorporate cultural values and beliefs.[103] These adaptations are important because although older people of color may not be concerned with whether their mental healthcare providers are from the same ethnicity or speak the same language as them, a sense of cultural understanding is still appreciated and reflects more positive

health outcomes.[26] It is also important because use of culturally informed clinical strategies and tailoring of interventions to the unique circumstances and backgrounds of the patient may influence engagement and retention in care. Adaptations such as language concordant intervention material can increase engagement. In one example, the term “nervios” (“nerves”) which is extensively used as a synonym for anxiety among Latinos was associated with less stigma than the formal psychiatric label of an anxiety disorder.[104, 105] These are opportunities to refrain from pathologizing culturally-relevant instances of mistrust and to remain mindful of the historical, cultural, and contextual experiences of older people of color and how those experiences relate to their treatment preferences. In addition to engagement, health outcomes may also improve as suggested by a meta-analysis showing that some culturally adapted psychological interventions had 4.68 times greater odds of producing remission than non-adapted conditions.[103]

“History-sensitive” mental healthcare represents one way in which the mental health system can reduce older people of color’s cultural mistrust of mental health.[34] Such an approach allows mental health providers to explore the meaning and interpretation patients assign to their own histories; decreases patient-clinician misunderstanding; yields an accurate diagnosis and course of treatment; enhances mental healthcare utilization; and reduces morbidity and mortality in marginalized populations.

Models of Care

For older people of color, different models of care that can address their social and cultural contexts are needed to increase access to and engagement with care. Investment in social services that increase equitable access to nutrition, education, child care, community safety, housing, transportation, and worker benefits can lead to better health outcomes for people of color.[106] For example, Latino patients may benefit from traditional psychotherapy if enhanced with case management, leading to better retention and potentially better outcomes.[107,108] Cultural competency training for staff and recognizing the family orientation of many older people of color, can help decrease stigma and increase access and engagement with mental healthcare services.[19,109] Furthermore, models of care would benefit from the integration of cultural norms around help-seeking and experiences of immigration and address the language needs of patients of color by ensuring diversity among treatment providers, including bilingual providers.

Collaborative care models may be more successful in reducing disparities in access to care if culturally responsive. One collaborative care study that was not culturally tailored decreased barriers for low-income patients, but did not reduce racial and ethnic disparities in access.[110] Another study that aimed to reduce disparities in unmet needs invested significantly in community-based collaborative care and cultural tailoring of the intervention.[111] Practitioners tailored the intervention materials and provided training to healthcare providers on cultural beliefs and ways to overcome barriers to care for Latino and African American patients. In this study, older people of color experienced a reduction in depression that was significantly higher than White older adults.[111] These findings highlight the potential impact that cultural adaptations can have on disparities in mental health access and outcomes when integrated into collaborative care models.

Utilizing community based participatory research approaches would be beneficial in engaging and reaching older people of color. One way of achieving this is employing community health workers (CHW) who can bridge the clinic and community divide. CHWs is a broad term that includes *promotoras*, peer specialists, lay health advisors, and patient navigators.[112] CHWs are seen as having an important role in promoting health equity and address health disparities. They provide a variety of services, mostly aimed at bridging the gap between patients and the healthcare system but also include social supports.[113] Given the lack of diversity in the professional healthcare workforce, CHWs can enhance the cultural competence of healthcare services due to their close connections with the population through their shared language and vast cultural knowledge.

This task shifting approach can also reduce practical barriers to care through the provision of low-cost yet effective interventions, offered in the community and in a timely manner.[113] States can provide Medicaid payment for CHW services under state plan or Section 1115 Waiver. However, Medicaid coverage of CHW services is limited and not uniform across all states.[113] Payment models for CHW services are expanding, and standardization would enhance the feasibility of integrating CHW into healthcare services. Continued study and evaluation of the impact of existing CHW programs will be needed to incentivize broadening coverage.

A clinic-based model can integrate CHWs to provide outreach into the community in multiple roles: for navigation of the mental health system, to address social determinants of health, and to deliver evidence-based therapies to reduce depression.[112] Using CHWs specifically dedicated to mental health conditions can activate patients in their self-care and providing culturally competent care.[112]

Models of care that partner with the community to increase community capacity for self-care and/or link patients to the healthcare system as needed can also be effective. Social services organizations are positioned to work in partnership with healthcare systems to identify older adults who need mental health services and provide programs that are conveniently located. Community-based mental health initiatives that integrate with other social services may be easier to access, be more trusted, and be associated with decreased stigma than standalone clinics. This model of care increases community capacity to target disparities by partnering with local community-based agencies to create a network for mental healthcare.[114] For example, a number of physicians of color, legal and financial service providers, church groups, senior centers, diagnostic and treatment centers, community and caregiver education, support groups, day care, and end-of-life services are identified to form a network that can be used to refer patients and their families for care. The model uses a “care advocate” who liaises with the patient and family and connects them to this network. A network like this deepens community capacity in terms of knowledge and resources for mental healthcare in marginalized communities.[115]

An Ounce of Prevention

The aphorism of Benjamin Franklin, “An ounce of prevention is worth a pound of cure,”[116] illustrates that people have long recognized the potential value in preventing something before it happens. However, it is only recently that scientific attention has been paid to

preventing mental disorders in older adulthood. The IOM[117] developed a framework for preventive interventions built around the target population: universal, selective, and indicated prevention. In universal prevention, the entire population base, regardless of risk, is targeted. An example would be outreach through media to promote protective factors and well-being through exercise, healthy sleep, and dietary practices, and to educate the general population about the early warning signs of depression. Selective prevention focuses on those who are at risk to develop the disease due to the presence of well-known risk factors such as disability, social isolation, bereavement, and chronic insomnia. Indicated prevention is directed at those at highest risk, specifically, people who are living with some symptoms but are below the symptom threshold that would indicate disease.

Numerous efficacious evidence-based treatments for depression and anxiety have been culturally adapted and translated to better serve racially and ethnically diverse populations. However, currently available pharmacologic and psychosocial treatments are only partially satisfactory in reducing symptom burden, sustaining remission, and averting years lived with disability for older people of color.[118,119] Moreover, the social worlds that put older adults at risk for depression, especially those living in low-income neighborhoods (who are often people of color), also act to reduce the effectiveness of antidepressant treatment.[120] Therefore, preventing depression and anxiety in later life would decrease suffering, morbidity, and mortality. This is particularly important for underserved and marginalized communities in whom disparities in mental health services and outcomes are pronounced. As discussed above, many older people of color have limited access to mental health treatment[6] and, for reasons of stigma,[8] are often reluctant to engage in help seeking; thus, underscoring the importance of preventing depression and anxiety from taking hold in the first place. The evidence to date suggests that such prevention tools are either available or can be readily developed and tested.[118,119]

Demonstrating the efficacy of a low-cost, task-shifting approach to prevention of depression is relevant for communities in short supply of mental health resources. Culturally tailored depression and anxiety prevention tools have been developed and are being implemented across the U.S. For example, Reynolds and colleagues[122] conducted a randomized controlled trial (RCT) of prevention via problem-solving therapy (PST) to prevent episodes of major depression, diminish disability, and improve health-related quality of life in low-income older adults (35% of whom were African Americans) who had risk factors for depression and were already mildly symptomatic. The control condition was health education in dietary practices. Results showed that both PST and dietary coaching are potentially effective in protecting older Black and White adults with subsyndromal depressive symptoms from developing episodes of major depression over 2 years.

Another randomized prevention trial is currently examining the effectiveness of the Happy Older Latinos are Active (HOLA) health promotion intervention in reducing the risk for and incidence/recurrence of major depression and generalized anxiety disorder in a diverse sample of older Latinos (NCT03870360). If effective, HOLA can be explicitly linked to preventing depression and anxiety in older Latinos and rapidly disseminated as a scalable, low-cost prevention intervention throughout the country. This study may exemplify the use of health promotion with minimal use of resources in an era in which funding for preventive

health services, particularly within mental health, is lacking. Although these studies hold promise, significant work remains in demonstrating the longer-term sustainability of such prevention strategies in older people of color.

Practical Strategies to Reduce Disparities and Increase Health Equity

Targeted strategies are needed to increase the inclusion of older people of color in mental health research more broadly. According to the Food and Drug Administration, 86% of the participants of clinical trials are White.[123] Similarly, studies conducted in 2018 and 2019 for dementia focused mostly on etiology, detection and diagnosis, and 89% of participants those studies were White.[124] This is particularly concerning in that low participation can compromise the generalizability of study results to people of color and sub-groups within those populations.[125,126] Multilevel strategies can be used to address this problem. A diversity of investigators and professionals who conduct clinical trials and population health research is needed to develop culturally relevant models of care.[127] Additionally, research that prioritizes recruitment by reducing the barriers to research participation is needed. This can be done by both understanding motivations, values, and attitudes around participation among older people of color and developing a strategic and systematized plan to organize outreach to minoritized communities.[126]

Health promotion and nutrition supplements as interventions—There is growing evidence to suggest that health promotion interventions – defined as behavioral interventions that use counseling strategies to equip participants with the necessary knowledge and skills to modify and sustain a healthy diet, increased physical activity, and/or healthy weight – can lead to improved mental and physical health outcomes.[128,129] Health promotion interventions are behaviorally activating, reduce vulnerability factors, and may be more desirable for reasons of safety and patient preference. Furthermore, health-promotion interventions can lead to improved mental and physical health outcomes in part due to increased engagement in preventative services.[130] Given that older people of color have low rates of mental health service use,[6] experience high stigma,[121] and have high rates of comorbidities,[131] mental health services that include strategies that enhance general well-being and bring mental health benefits are needed. Health promotion may be a culturally appropriate and non-stigmatizing alternative that could address multiple disparities in minoritized communities.

Food is often used to reflect cultural values, and meal traditions often serve as cultural markers that help define social groups and individual identities.[132] Healthy food interventions and nutritional supplements are increasingly regarded as potentially valuable alternative strategies for mental healthcare and illness prevention due to dietary patterns that can be locally adapted based on food availability, low cost, ease of use, and cuisine traditions.[133] Given that obesity and diabetes is more prevalent in older African-Americans and Latinos than in older Whites,[131] an intervention designed to improve dietary practices and promote a healthy diet in older people of color could be seen as culturally acceptable and salient and could potentially have a positive impact on mental health. There is a small but expanding body of literature suggesting protective associations between healthier diets and mental health problems.[134,135] However, more scientific evidence is needed to

demonstrate both efficacy of nutritional strategies as well as their roles in reducing mental health disparities for older people of color.

Observational studies generally indicate that poor nutritional status is a risk factor for depressive disorders in older adults; however, limited evidence exists to support the use of dietary supplements to prevent late-life depression. For example, although low blood levels of B-vitamins have been linked to depression in observational studies, RCT data do not provide support for use of B-vitamin (B6, B12, folate) nutrient supplements to prevent depression or reduce depressive symptoms among healthy older adults who are adequately nourished.[136,137] Similarly, although low blood vitamin D levels are associated with depression risk in older adults, including among older Black adults, existing data from larger RCTs have not shown benefit on depression outcomes possible due to study limitations (e.g., low doses, short treatment durations, lack of participant diversity).[138–141] Thus, larger, longer-term RCTs of adequately-dose vitamin D and composed of racially/ethnically diverse participants (e.g., VITAL-DEP study[142]) is needed to provide more clarity.

Family interventions—Family is an untapped resource in mental healthcare particular among older adults. U.S. older adults spend more than half of their available time with family and friends and are more likely to discuss health issues with family than with anyone else.[115] Moreover, families play an important role in the minoritized groups where disparities in mental health treatment exist.[143] Therefore, developing family interventions for older people of color with mental health issues may be a culturally relevant strategy to improve mental health outcomes for these patients and reduce disparities in mental healthcare.

Family interventions can be largely categorized into three approaches. First, psychoeducational approaches, in which interventionists work alongside caregivers to increase not only their mental health literacy, but also their self-efficacy to care for the older family member. Second, interventions may engage with the aging patient to improve their social skills and functioning. Third, interventionists can directly target a patient-family dyad through either couples or family therapy to modify maladaptive couple or family functioning.

Cultural variations in family processes must be carefully considered when developing and implementing family interventions for older people of color. For example, there is a general consensus in the literature that family cohesion and family conflict is associated with depression. However, a recent study concluded that, while both family cohesion and family conflict were significantly associated with depression in the older Asian American population; only family cohesion was significantly associated with depression in the Latino older adult population.[143] More information is needed to fully understand how cultural variations in family processes may impact treatment of mental health issues among diverse, vulnerable older people of color.

CONCLUSION

Although mental health disorders do not discriminate based on race, ethnicity, or age, older people of color face a disproportionate number of challenges across the care continuum due to racism, which is the root cause and the ongoing driver of mental health disparities. The process by which older people of color have coped with racism also facilitates an understanding of the context to differential expressions of psychological distress and possible mistrust of certain clinical recommendations. Being marginalized and excluded from formal mental health resources for decades through various mechanisms of racial discrimination fostered a dependence on spiritual and familial coping. To better support older African American, Asian American, and Latino individuals living with or at increased susceptibility for mental health concerns, it is imperative that researchers, clinicians, and policymakers acknowledge the realities of racism and discrimination as leading causes of mental healthcare disparities and work collaboratively across disciplines to increase equity in mental healthcare.

DISCLOSURES

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DATA STATEMENT

The data have not been previously presented orally or by poster at scientific meetings.

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Highlights

- What is the primary question addressed by this study?

  Mental healthcare disparities are routinely documented, yet they remain wider than in most other areas of healthcare services and common mental disorders (depression and anxiety) remain as one of the highest health burdens for older people of color.

- What is the main finding of this study?

  Although mental health disorders do not discriminate based on race, ethnicity, or age, older people of color face a disproportionate number of challenges across the care mental healthcare continuum due to internalized, interpersonal, systemic, and medical racism.

- What is the meaning of the finding?

  To better support older African American, Asian American, and Latino individuals living with or at increased susceptibility for mental health concerns, it is imperative that researchers, clinicians, and policymakers acknowledge the realities of racism and discrimination as leading causes of mental healthcare disparities and work collaboratively across disciplines to create, implement, and evaluate culturally-tailored interventions that acknowledge the diverse needs of these often-overlooked populations.

TABLE 1.

Differences in Mental Health Outcomes by Race/Ethnicity and Implications for Intervention Development

Mental Health Outcomes	Black	Asian	Hispanic/Latino	Intervention Considerations
Overall past-year psychiatric comorbidity	9%; on par depression however more severe chronicity and other health outcomes	7.8%	Higher rates of depression and chronic stress; comparable rates of anxiety	Greater emphasis on developing more culturally-sensitive tools for measuring psychiatric disorder that incorporates different symptom profiles and implicit diagnostic bias by clinicians.
Overall psychiatric comorbidity	23%; lower depression (potentially underdiagnosed)	14.6%	Higher rates of depression and chronic stress; comparable rates of anxiety	Inclusion of specific trainings to reduce prejudice in diagnostic and assessment of disorders, challenge existing myths about racial/ethnic minority groups (e.g., model minority), and educate clinicians about the realities of mistrust and racism within healthcare settings.
Post-traumatic stress disorder	Highest rates of trauma	High rates among Asians with migration histories		Creation of interventions that specifically aid in reducing overt and covert acts of discrimination towards racial/ethnic minorities.
Schizophrenia	Overdiagnosis particularly among men		Overdiagnosis particularly among men	Develop interventions that help facilitate coordinated models of care rather than medicalized models. Reduce race-based trauma; improvements to coordinated models of care Clinician prejudice and contextual diagnostic analysis – issues with realities of mistrust and racism.
Self-harm and suicidal ideation	27%	56.8% (particularly among women); rates increase as people age compared to other racial groups		Emphasize interventions that target on reducing social isolation, loneliness, and financial hardships among older racial/ethnic minorities. Bolstering interventions that reduce overall psychiatric morbidity among older racial/ethnic minorities can help reduce suicidal ideation and self-harm among this population.
Health care utilization	Less likely to use prescription medication for diagnosable MH disorders; significant underutilization of MH services (e.g., psychotherapy)	Less likely (2–5× compared to Whites) to receive mental health services	Less likely to initiate mental health treatment, even when needed; 2–3× more likely to drop out of treatment	Advocate for programming and legislation that reduces structural barriers to care (e.g., health insurance, accessibility of providers, poverty). Offer alternative forms of care that may be more appealing to older racial/ethnic minorities (e.g., group therapy). Adapt current interventions with a culturally sensitive lens that address language barriers, lower education and health literacy levels, and bias among providers. Elevate more providers who are bilingual or trilingual and come from similar cultural backgrounds to older racial/ethnic adults.
Mental health stigma	Greater than Whites	Greater than Whites - due to mind-body dichotomy holistic health view; greater belief that social factors cause illness rather than biology	Greater than Whites – MH challenges caused by loss of family and friends, interpersonal issues, moving; supernatural reasons (e.g., God)	Include intervention components that directly address culturally specific stigma narratives. Design interventions that focus on stigma stemming from intersectional identities (e.g., age, race, ethnicity).
Protective health beliefs	Strong social network, optimism bias, spirituality	Strong familial support, religiosity/spirituality, peer and social support networks	Familismo, personalismo, acculturation	Balance risk-focused intervention components with those that are resilience based to highlight the various protective factors experienced by racial/ethnic minority groups. Develop interventions that engage peer, family, and social networks as a means of reaching and supporting older racial/ethnic minority adults.

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