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Stigma and Systemic Barriers

Why Mental Health Care Is Not the Same for Everyone

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There is no question that Coloradans' mental health suffered during the height of the COVID-19 pandemic. Daily routines were disrupted, and many experienced social isolation, loss of income or employment, or grief for the more than 7,000 Coloradans who have died.[1]

The pandemic also revealed, in stark relief, racial inequities that have long existed in our society. Black and Latinx people in Colorado and nationwide have been disproportionately harmed by COVID-19. They were more likely to get the disease and die from it and more likely to report symptoms of anxiety and depression.[2] The mental health of people of color was further harmed by unjust police killings of Black people and xenophobia and violence against Asians.[3,4]

These inequities have resulted from historical exclusion and racism that continues to pervade our education, criminal, housing, and health care systems. Experts anticipate increased mental health needs in the wake of COVID-19, which heightens the need to address stigma and systemic barriers that create disproportionate access to mental health care for people of color.

Key Takeaways:

- Stigma is a common barrier to accessing mental health care. For people of color, harmful notions related to stigma can be magnified.
- Good health is not equally distributed, and systemic problems that result from centuries of racism and discrimination continue to negatively impact health outcomes for non-white Coloradans.
- Building a foundation of cultural competency and trust is crucial for improving access to care and outcomes for people of color.

A Word About Racial and Ethnic Data

For several racial/ethnic groups — Black, Hispanic/Latinx, Asian, American Indian/Alaskan Native, and multiracial — we sometimes only have enough sample size for two or three groups. CHI recognizes that these race/ethnic groups are not a monolith, but rather have diverse experiences and needs. The report will sometimes group many of these race/ethnic groups into one group called "other race" only to provide a reportable sample size. Labels/groupings for different race and ethnic groups may also vary throughout the paper based on their source data, for example, Hispanic/Latinx.

Stigma Limits Mental Health Care

Mental health stigma is a persistent challenge for many. Nearly half (47.3%) of Coloradans who said they did not get needed mental health care cited stigma as a reason in 2019.[5] There are countless reasons a person can be reluctant to seek care, but for people of color, cultural factors can make the stigma around mental health especially difficult to overcome.

While the experiences of different racial and ethnic groups and individuals are unique, some harmful notions about mental health can be magnified for people of color. These mental health myths create additional hurdles to seeking care.

Myth: *A mental health condition is nothing compared with the hardships experienced by previous generations.*

African American ancestors endured slavery and segregation; Native American elders faced violence and forced relocation at the hands of the U.S. government; Latinx and Asian parents and grandparents fled oppressive regimes or sacrificed their lives in search of safety. Comparing others' lived experiences can lead people to minimize their own mental health concerns or have their concerns minimized by family members.[6] But in many cases, intergenerational trauma — trauma that is passed through subsequent generations — can contribute to the presence of a mental health condition.

Myth: *A mental health condition is a sign of weakness.*

This widespread misconception can be further perpetuated by cultural experiences. Asians are burdened with high expectations for success, as dictated by society's harmful model minority myth.[7] Inaccurate societal views of Black and African American males as heteromasculine, unemotional, and aggressive create pressure to appear strong.[8] In these examples and others, showing emotion or acknowledging a mental health condition can be portrayed as a sign of weakness, leading to a reluctance to seek care.

Myth: *A mental health condition is shameful.*

Embarrassment or concern over a mental health condition reflecting poorly on one's family causes many people to forgo needed care. In many cultures, talking openly about mental health conditions can be viewed as taboo. This may be due in part to varying cultural perceptions that can attribute mental health concerns to supernatural causes or other reasons that instill shame.[9] As a result, many choose to suffer in silence.

Systemic Barriers Disproportionately Affect Health

Compounding mental health stigma is the system of oppression that exists from centuries of racism and discrimination. Colorado is not exempt from this history. One example is Amache, also known as the Granada Relocation Center, where over 7,000 Japanese Americans, most of whom were American citizens, were forcibly imprisoned following the attack on Pearl Harbor. Redlining — a discriminatory practice that started in the 1930s that denied mortgages in predominantly Black neighborhoods — has produced worse health outcomes for many of Denver's communities, such as Valverde, an area north of Alameda Avenue and west of Interstate 25. The poor built environment of the area, including proximity to a busy highway and lack of walkability and healthy food stores, contributes to greater risk of developing chronic conditions, like those that increase the risk or severity of COVID-19. Valverde has had one of the highest COVID-19 hospitalization rates in Denver.[10]

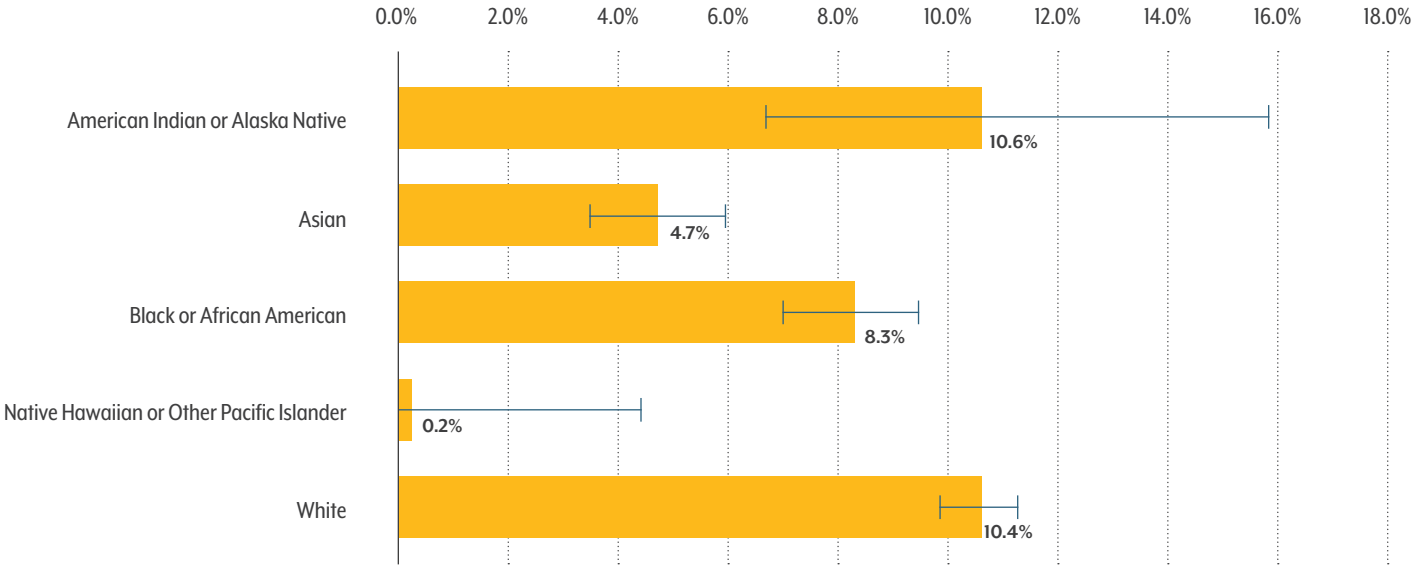
These, among other examples of racism and discrimination, add to existing intergenerational trauma. Good health is not equally distributed, and systemic problems continue to negatively impact health outcomes for people of color.

Evidence: *Systemic barriers prevent people of color from accessing care and treatment.*

For as long as the U.S. has existed, people of color have faced race-based exclusion from accessing health, educational, social, and economic resources. Today, disparities persist and are reflected in lower rates of health care access and treatment. Data from the Centers for Disease Control and Prevention (CDC) show that white adults were significantly more likely to have received mental health counseling in the past 12 months than Black or African American, Asian, or Native Hawaiian/Pacific Islander adults[11] (see Figure 1).

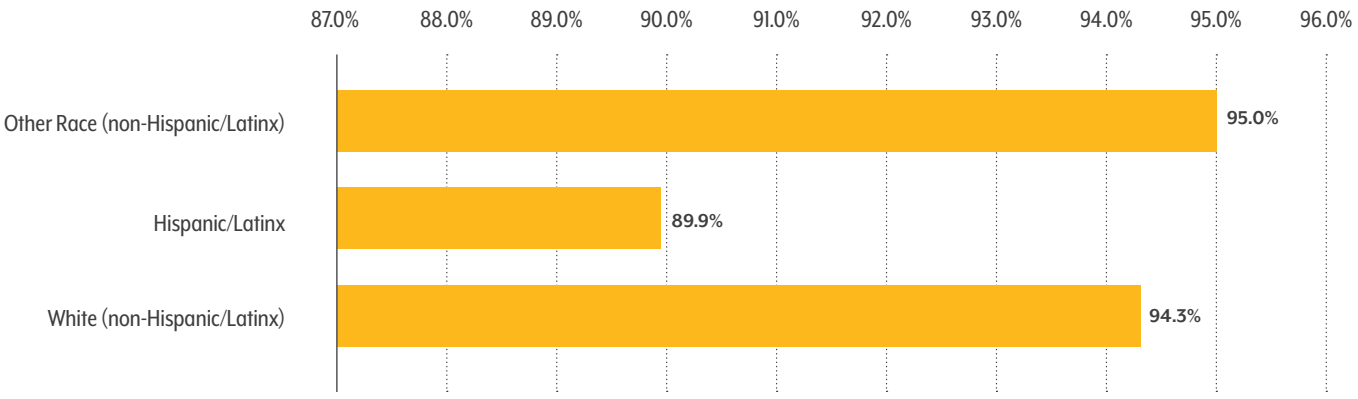
Insurance presents another barrier. If people lack health insurance, they are less likely to use health care because of the expense. Hispanic/Latinx Coloradans report lower rates of insurance coverage compared with those of other races[12] (see Figure 2). Reasons for this disparity include poorly paying jobs that do not offer employer-based insurance and policies that limit enrollment in health care coverage based on immigration status.[13]

Figure 1. Percentage of Adults Who Received Counseling or Therapy During the Past 12 Months (95% confidence intervals), 2019



Source: CDC National Health Interview Survey, 2019

Figure 2. Percentage with Health Insurance by Race/Ethnicity, 2019



Source: 2019 Colorado Health Access Survey

Evidence: *Abuses within the medical system have created deep mistrust in many people of color.*

Mistreatment of people of color in the health care system is rooted in U.S. history, such as the Tuskegee syphilis study and the forced sterilization of Native American and Black women. And today, negative experiences, misdiagnoses, and inadequate treatment persist. Compared with white patients, African American and Black patients are misdiagnosed at a higher rate with schizophrenia spectrum disorders and are less likely to be offered needed antidepressant therapy, even when they have access to insurance or financial resources.[14,15] The soundly disproven stereotype that Black people have a higher pain tolerance continues to pervade the health care system, negatively affecting pain management for Black patients.[16]

Among Coloradans who reported sometimes or often being treated unfairly when seeking medical treatment, 17.1% responded that their race or skin color was the most likely reason.[17]

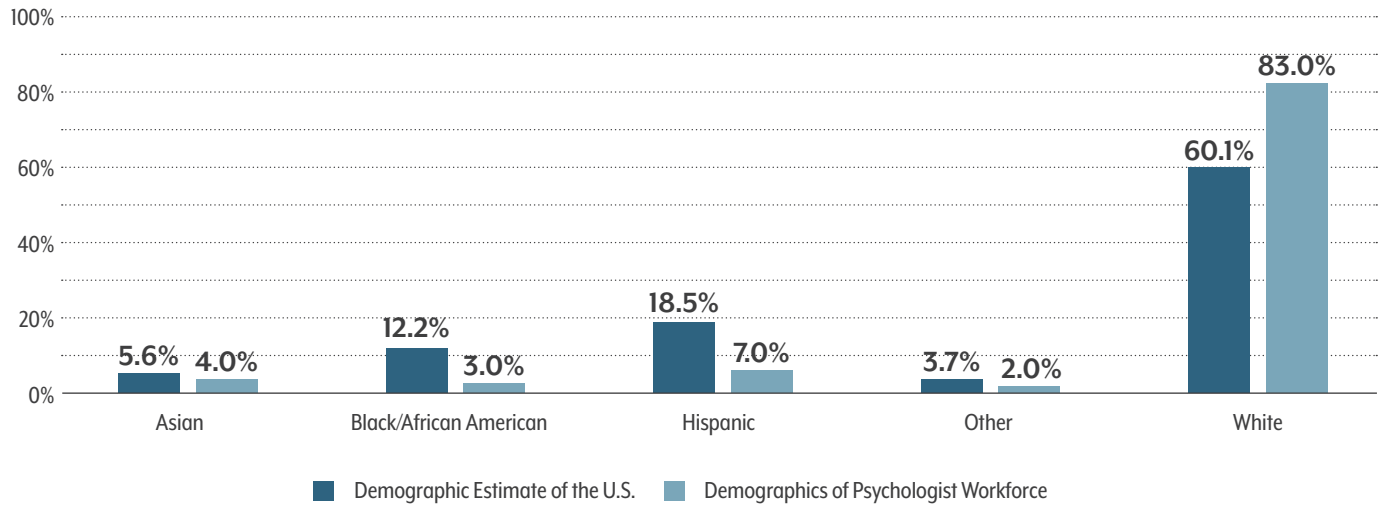
Evidence: *There is a shortage of culturally and linguistically competent providers.*

The racial and ethnic diversity of the country is increasing. About 40% of people in the U.S. identify as non-white.[18] However, representation in the medical field has not kept pace. For example, only 16.0% of the U.S. psychologist workforce is non-white[19] (see Figure 3). Beyond racial and ethnic diversity in the medical field is cultural competence. Aging of the current workforce, low rates of reimbursement, and lower salaries in community-based behavioral health positions create a workforce shortage that contributes to the lack of health care providers who are linguistically and culturally competent.[20,21]

Cultural competence displays empathy, compassion, and mutual respect for a patient which can address issues of mistrust. Culturally and linguistically competent providers are critical to delivering effective, patient-centered care. They can overcome language barriers and are more familiar with the ways people can describe physical symptoms to avoid talking about their mental health.[22] Failing to pick up on these nuances can lead to misdiagnoses and ineffective treatments, and it could explain the lower reported prevalence of some mental health conditions among non-white groups.[23]

Figure 3. Race/Ethnicity Demographics of the U.S. Population and the Psychologist Workforce, 2019

Sources: American Psychological Association (2020). Demographics of U.S. Psychology Workforce [Interactive Data Tool] and 2019 Kaiser Family Foundation Population Distribution by Race/Ethnicity of the U.S.



Mental Health of Immigrants, Refugees, and Asylum Seekers

Mental health stigma can be common among refugees, asylum seekers, and immigrants. Unfortunately, these groups are at risk for worse mental health outcomes because of the presence of trauma before and after migrating, which is compounded with experiences of racism and discrimination, adjusting to new cultures and lives, and barriers to accessing mental health care.[24] Federal policies also limit access to care for many immigrants and refugees.

In 2019, the Trump Administration expanded the "public charge" rule to say the use of Medicaid and other programs could be grounds for denying a person's citizenship application. While the Biden Administration repealed those changes in 2021, data show the consequence of the changes: Almost one in six adults in immigrant families reported in 2020 that they or a family member avoided a noncash government benefit program, like Medicaid, over concerns about green card applications and immigration.[25] Harmful effects of the policy continue to linger as many remain hesitant to enroll in public benefit programs.

The Compacts of Free Association (COFA) migrants provide another example of a systemic barrier that has limited access to care. COFA migrants should have had access to social and health services, such as Medicaid, as partial compensation for the loss of life, health, land, and resources due to numerous U.S. nuclear weapons tests in three Pacific island nations. But a 1996 law inadvertently restricted these benefits for COFA individuals, and the error was not fixed until just last year.[26]

"Public charge and COFA are some of the biggest barriers for immigrants and refugees... What the community heard is that they would be denied immigration status if they use public benefits. They feared they would be deported. It's hard to get people to sign up for benefits when they're being told they'll get deported if they do, or if they actually can't."

— Harry Budisidharta, Executive Director, Asian Pacific Development Center

Conclusion

Decades of mistreatment and discrimination have created daunting barriers for people of color to engage with the health care system, in Colorado and across the country. This system of oppression will continue to create disparities unless the legacy of unequal treatment and harmful stigma is dismantled equitably at all levels of the health care delivery system — from reducing bias through medical school education to implementing community-based interventions, and increasing funding for mental health research that is inclusive of people of color.[27] These systemic changes are critical to building a foundation of cultural competency and trust.

In the meantime, leveraging protective factors among communities of color can help address the stigma that contributes to mental health myths and break down some systemic barriers to care. These opportunities — and examples of how many Colorado organizations are supporting communities of color — are detailed in CHI's forthcoming report, *Resilience and Protective Factors: Avenues to Improving Mental Health and Reducing Health Disparities.*

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Endnotes

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