Lisa Dixon (00:07):

Welcome to our podcast, Psychiatric Services From Pages to Practice. In this podcast, we highlight new research or columns published this month in the Journal of Psychiatric Services. I'm Lisa Dixon, editor of Psychiatric Services, and I'm here with podcast editor and my co-host, Josh Berezin. Hi, Josh.

Josh Berezin (00:27):

Hi, Lisa.

Lisa Dixon (00:27):

Today we're going to be talking about a data-rich article, we love data, focused on disparities in participation in mental health treatment over the last decade or so. Tells a really important and in many ways troubling story.

Josh Berezin (00:42):

We're happy to have Navdep Kaur, who is a PhD student at Columbia Mailman School of Public Health in the Department of Epidemiology here on the podcast to talk with us about her recent paper, Trends in Racial-Ethnic Disparities in Adult Mental Health Treatment Use From 2005 to 2019. So Navdep, welcome to our podcast.

Navdep Kaur (01:01):

Thank you for having me.

Josh Berezin (01:03):

How did you get interested in this topic?

Navdep Kaur (01:06):

It's largely informed by my lived experience. I was born and raised in New York City, which is obviously an incredibly diverse population. Almost half the city is foreign born, and that includes my parents who came here in the '80s as undocumented immigrants. And so we know that the struggle of being an immigrant or a member of a minoritized group in general can lead to poor mental health. And so I grew up around friends and family who struggled with their mental health and, for one reason or another, lack of insurance, lack of knowledge about how to access mental health services, could not get treatment.

(01:50):

And what I noticed was these friends and family members were all racial and ethnic minorities, and the friends I had who were able to access mental health treatment were all white. And this was a very consistent theme in my life. And so basically, I saw these disparities playing out in front of my eyes and I couldn't ignore it anymore. And witnessing that informed the trajectory of my career. It's also why I'm so deeply passionate about my work, because I'm personally invested in making sure that it's high quality because it directly serves my people.

(02:28):

And it's the reason why as an adult, I spend a lot of my time sharing my own experiences receiving mental health treatment in the social spaces that I occupy, which are largely filled with racial and ethnic minorities. And I think that advocacy work is part of the movement, really. But I will say, little asterisk,

that this revelation of my personal connection to my research really started when I started working with Kerry Keyes at Mailman. She really opened up door after door to help me find my niche, and I'm truly grateful for her mentorship. But that's really how I got interested in the topic, a long, windy road.

Lisa Dixon (03:09):

I want to just say something here, because it gives me such pleasure to hear you connect your work with your passion. And I can't tell you how many times I've tried to give permission to people that I've worked with over the years to do that. I personally do it because I have a brother who lives with schizophrenia, and it had a big impact on me growing up in my young adulthood, I guess. And people are so afraid, I think, to connect with that passion, with that personal experience, and sometimes I think it just has to do with stigma. But I just wanted to give you a shout out and say, I am so glad to hear your comfort with that and your forthrightness. It really is a pleasure to hear.

Navdep Kaur (04:00):

Thank you, Lisa. I appreciate that.

Josh Berezin (04:01):

Where were you headed before you got that mentorship?

Navdep Kaur (04:04):

How did I get there? I was really meandering, to be honest. I got my master's from Mailman. And often, actually, the students that I TA, they'll often come up to me and ask this exact question. And my answer to them is, it was trial and error, to be honest. It didn't connect for me until I started working as a data analyst with Kerry, that I do have this personal connection and it makes me so much more invested in the work that I do. But before that, I was working in global health. I worked at Harvard for a little bit. I worked at a different department within Mailman. I was a little bit all over the place before I found my passion, and it came from such a personal place, as I mentioned.

Josh Berezin (04:46):

So passion plus mentorship equals a fulfilling...

Navdep Kaur (04:52):

Yes. Thank you, Kerry.

Josh Berezin (04:53):

Is our take home from the intro right now.

Navdep Kaur (04:55):

Yes, truly, truly. I can't just say that it came truly from within me. I think Kerry and Pia Mauro and all these other amazing mentors that I've had have really shown me the way, and AJ, hopefully you'll listen to this.

Josh Berezin (05:12):

Getting into the paper a little bit, it seems like the passage of the ACA, the Affordable Care Act, in 2012 is a big part of the background for the paper. If we were back in 2011, 2010, what did we know about racial-ethnic disparities and treatment access then? And if you were advocating for the ACA and said, this is where we should be in 10 years because of the ACA, what would that person have said?

Navdep Kaur (05:39):

Yeah, that's such a good question. And you're right. It is a huge part of this paper and a huge part of my motivation. In the future I'd like to continue working on policy and how it relates to mental health treatment. To answer your question more directly, what we know about treatment disparities pre-ACA is that the disparity between white, Black, Hispanic and Asian people increased or remained unchanged in the past decade leading up to 2012. And that's largely where that research halts. But in terms of the ACA, there were two main aspects of the policy that are relevant to mental healthcare. I'm sure you know that one of them is the expanding of Medicaid access to more people. And then the second aspect of it was making mental health services "an essential health benefit," so that they it to be covered by insurance.

(06:33):

And so ultimately, the general expectation was that the increase in insurance access would eventually translate into more equitable access to care, including mental healthcare. But then bringing it to this paper, what we found in the paper was that despite the ACA, disparities in mental health treatment are largely persisting. And so overall, this paper in combination with others tells a story that these disparities have actually been occurring at least for the past two decades that we have in the literature. And so in terms of the ACA specifically, to answer your sort of cheerleader part of the question, in my opinion, anything that moves this country towards a universal healthcare framework is a win.

(07:24):

And any policy that reduces the number of uninsured people in this country is great. But there were certainly some downsides to ACA implementation. The implementation is highly variable at the state level, so some states implemented it and some didn't. And that means that it's possible that these disparities that we saw in this paper might vary greatly between states. There's also the issue of state level insurance marketplaces that are inherently decentralized because they're run by each state individually, which comes with its own challenges.

(07:58):

And then, I don't know if you've tried navigating the one for New York State, but I tried navigating it for multiple family members, and it's very difficult to actually navigate and find the insurance that you want. And then there are tons of other issues that come with the ACA framework that I'm still learning about as a student. And so in terms of the first 10 years of the ACA, which we're about to reach in 2024, because it was implemented in 2014, particularly in the state of New York, I'm not optimistic that it will fulfill its intention unless we move closer to a single-payer framework. I think that might help.

Lisa Dixon (08:35):

Just so I understand, and I think I do, but I want to make it explicit, the promise of the ACA was that it would address some of the disparities. Is that correct? That would've been the part of the story, perhaps, that we would've hoped that we could tell. Is that correct?

Navdep Kaur (08:56):

Absolutely, Lisa. The expectation was that hopefully this uptake in insurance would lead to more equitable access to care. And what we're finding in this paper is that at least for mental health treatment in these particular high-risk groups, we're not seeing that.

Josh Berezin (09:11):

So let's take a step back. What did you look at in the study to be able to come to that conclusion? What were some of the methods that you used in this paper to figure that out?

Navdep Kaur (09:21):

Sure. That's a great question. So just broad strokes, what we did was we used nationally representative data from a publicly available dataset called NSDUH, or NSDUH, it depends on who you ask. But what we did was we documented trends in racial-ethnic disparities in mental health treatment use, and we focused on adults 18 and older. And we also focused on adults who were experiencing one of the following mental health issues in the past year. It was either a major depressive episode in the past year, serious psychological distress or serious mental illness as defined by NSDUH.

Josh Berezin (09:59):

So just to drill down a little bit, what are these groupings? What are we talking about when we're talking about distress, for example?

Navdep Kaur (10:06):

Sure. That's a good question. NSDUH uses the Kessler 6 screening instrument that you may be familiar with. It's a validated measure, and they use it to assess this broad category of psychological distress in the past year. And so to give you more information on the Kessler 6, it's a six-item scale that measures the frequency of feeling nervous, hopeless, restless or fidgety, sad or depressed, that everything was an effort, or being down on oneself, no good or worthless. So they use this, convert it to a Likert scale, and then that becomes the measure, the final measure.

Josh Berezin (10:45):

Just to round that out a little bit, how did they define serious mental illness?

Navdep Kaur (10:48):

Sure. That one is a little bit more complicated. They defined serious mental illness as a diagnosable mental, behavioral or emotional disorder, resulting in serious functional impairment during the past year.

Lisa Dixon (11:03):

It's very interesting. We had a paper relatively recently on the problems with the whole serious mental illness, severe mental illness diagnostic cluster, that it's just very inconsistent. There was a review on this. But with NSDUH, I think you get what you get.

Navdep Kaur (11:21):

100%, Lisa. I know that we'll get into maybe some ideal data sets, but it's definitely a limitation of the data.

Josh Berezin (11:30):

You got this large scale survey and you've used it to define these groups of serious mental illness, for example. And then what you're looking at is treatment usage over time and whether or not disparities between different groups have changed over that time. But before we get into your findings, how did you define treatment usage? What are we talking about? What does that mean?

Navdep Kaur (11:52):

Mental health treatment in the past year is defined in NSDUH as receipt of inpatient treatment or counseling, or outpatient treatment or counseling, or use of prescription medication for what they're saying is problems with emotions, nerves, or mental health in the past year. So it's a very broad category.

Josh Berezin (12:11):

And it's all self-report.

Navdep Kaur (12:12):

Yes, correct.

Josh Berezin (12:14):

So maybe the easiest way to summarize what you did is to get in a little bit of your findings. So what are your top line findings, which you alluded to a little bit already?

Navdep Kaur (12:24):

We found that the magnitude of the disparity in treatment use between white and Hispanic adults with major depressive episode or with serious psychological distress decreased, but it did not significantly decrease for any other racial-ethnic group with any other mental health issue that we discussed in the paper. Like I mentioned, overall, this paper in combination with others tells this story that these disparities have actually been occurring for the past two decades.

Josh Berezin (12:53):

So you've got this finding that with the exception of the Hispanic population, disparities in treatment, they didn't really change for these groups since the passage of the Affordable Care Act. And I'm just wondering, what did you make of that? What are some of the hypotheses as to why that might be the case?

Navdep Kaur (13:11):

That's a great question. And so you're absolutely right. We saw decreases in treatment disparities between white adults and Hispanic adults for very particular mental health issues that we were studying. And the reason for that reduction is outside of the scope of this paper, but in the discussion we theorize that there's possibly lower social stigma in the Hispanic population towards seeking mental treatment. And there's also evidence that there's increased federal funding for organizations that focus on serving the needs of the Hispanic community. But I will say that more research is needed to parse the trends within the Hispanic and Latinx subgroups, because it is a huge umbrella group, to elucidate stronger hypotheses for these observed reductions.

(13:56):

And I do want to say that we are studying racial and ethnic groups, and that there is this one huge caveat, that racial and ethnic identity is so complex and so contextually dependent. And as I mentioned, Hispanic and Latinx people are so diverse and the unique experiences of the subgroups might highly vary. And so there's a similar issue with these other broad categories that we use, such as Asian people and Black people. These are actually really big umbrella categories. And so unfortunately, the public-use NSDUH only allows us to have access to these broad groupings. But my hope is that future studies will have the sample size to parse trends within these subgroups. That would be wonderful.

Josh Berezin (14:40):

Yeah. One of the things that popped out for me was also the definition of treatment use. So lumping in outpatient and inpatient treatment, for example, and how to interpret that. So if one group has much higher rates of inpatient hospitalization and much lower rates of outpatient hospitalization, another group is using outpatient services a lot more, but using inpatient services much less than another group, those seem like wildly different groups that we're talking about here. And to lump them into one category of access to treatment and that being something that we're moving towards seems like a challenge in the data set, similar to what you were talking about for the definition of the racial and ethnic groups.

Navdep Kaur (15:30):

Yeah, that's an excellent, excellent point. Understanding trends by treatment type was outside of the scope of this paper and obviously a limitation. But these trends are also very likely to vary once we get more granular about the type of treatment, which I want to mention is very consistent with the literature. So for example, there are tons of papers that show that Black people with serious mental illness are more likely to be involuntarily hospitalized and to enter emergency treatment by means of law enforcement compared to white people.

(16:03):

And honestly, we're all New Yorkers right now. We're all living in New York. We see this playing out in New York City. So very recently, Eric Adams said officials will begin hospitalizing unhoused people involuntarily. And we know in New York City that Black and Latinx people are disproportionately affected by homelessness. And so Eric Adams' policy to "crack down" on homelessness in the city is likely disproportionately going to affect Black and Latinx people. And so, long-worded story, but to answer your question, while we didn't investigate trends in different types of treatments in this paper, it's worth investigating in the future. And I truly do think that it will vary by treatment type.

Lisa Dixon (16:44):

Can I ask one further question? Because we've discussed disparities on this podcast a few times, and one of the points that's been made is that you can have treatment, say, increasing for everybody, but have disparity persist. So that the amount of treatment could be more or greater or less, but the access to treatment or use of treatment is a different factor or variable than the disparity.

Navdep Kaur (17:21):

Absolutely.

Lisa Dixon (17:22):

So wondering if you have an ability or the data you are able to capture in a meaningful way, whether the amount of treatment overall was greater for a particular subgroup or for the whole population.

Navdep Kaur (17:42):

So we are looking at predictive probability. So in reality, these trends are going up and down like this, but we're using the model to create these predictive probabilities. And so the predictive probability of treatment for, let's say, multiracial people, again, a highly variable group is either stagnant or declining, it depends. It's a hard question to answer, but I think what you're trying to get at is how do you define disparity in the context of this paper? So the way that we're defining disparity is the closure of that gap in treatment. So multiple groups may be increasing in their prevalence of mental health treatment, but it might be at the same rate and so the gap is not closing.

Lisa Dixon (18:22):

Exactly. Right.

Navdep Kaur (18:24):

But I will say ultimately the goal is to get a hundred percent treatment. This paper is interested in seeing whether the gap closes, but in reality, everybody should get treatment. It should be a hundred percent across the board.

Lisa Dixon (18:36):

Yeah, exactly. So a question could be, did ACA overall increase access to treatment, but it didn't reduce disparities?

Navdep Kaur (18:45):

Right. And so we were looking at trends pre and post, and so it's not directly dissecting the ACA as it relates to these treatments. But that is definitely a future direction that I'd like to go in.

Lisa Dixon (18:58):

So what we can say here is for the most part, except for the Hispanic-Latinx group, where the disparities diminished slightly, basically the real focus was on the disparity, and that did not change.

Navdep Kaur (19:13):

Exactly.

Lisa Dixon (19:14):

Between white and other groups.

Navdep Kaur (19:15):

Exactly.

Josh Berezin (19:16):

Also trying to think through some of the why behind it. You mentioned the study can't necessarily answer all of those questions, but you have some ideas. I thought your discussion was this really

fascinating combination of factors at different levels. So you have policy level factors, like you mentioned, differing uptake of Medicaid expansion across the states. You have structural factors. I love that you mentioned actual distance to clinic. That is a treatment access issue that differs across populations. How long does it take me to get somewhere? And then some of the questions that you were mentioning earlier around stigma and attitudes towards treatment. So do you have a way that you've categorized those various levels or that you think about those various levels?

Navdep Kaur (19:59):

I love that question, Josh. That's a wonderful question. And you're right, there are a lot of moving parts. There's these social factors, there's logistical factors, there's policy. And so what I learned from my mentor, Pia Mauro, very early on in my PhD career, is the importance of using frameworks to ground your research. And so currently what I'm using in my research, and I'm a big proponent of this, is using the sociocultural framework for the study of health service disparities. It was developed by Margarita Alegria and others.

(20:37):

And I really like it because it acknowledges that there is this fundamental interdependence, as you're mentioning, of legal, economic and social mechanisms in determining disparities in health services. And so I used this framework to determine precisely what part of the healthcare system I want to interrogate as a researcher. And for me, that's largely the healthcare market failure aspect. So that includes the policies, and that also includes how are we getting access to the healthcare system. But as you mentioned, just because my focus is on market failure doesn't mean I can ignore those other factors that also lead to disparities. And so that's why the discussion is so complex and intertwined.

Josh Berezin (21:21):

And just beyond my pay grade, but a market failure has to be explained at some point by the kind of lower, less macro levels. And so it's just really interesting that you can't get around that if you're talking about the individual or biological levels. You have to scale up to figure out what that's implicating for the larger levels. And I think what you're saying is that you've got one of the highest levels, policy, public health policy. But you've got to think about what does that mean for individual, and that it also differs across people's groups and all the other levels in between.

Navdep Kaur (22:04):

Yeah. I mean, to be honest, the literature shows that there has been an increase in insurance uptake after the ACA. And that's obviously a great thing, but there must be some other sources of market failure, like lack of providers that accept your insurance and things like that. And so those are the parts that I'm trying to dissect.

Josh Berezin (22:22):

So we've talked a little bit about some of the limitations of the dataset. And some of that is what you can access publicly, and some of it is how the questions are asked. If you could come up with a data set that would answer all the questions that you have, or your most important questions, let's start there. What would be your most important questions after this paper? And then what would a data set look like that could actually answer that?

Navdep Kaur (22:51):

Oof. That's a great question. Oh, I love that. So yes, there are certainly very important limitations to our study that are worth acknowledging. And so for example, the measures of mental health treatment are self-reported, and it's likely underreported because there's so much stigma around mental health treatments. And so NSDUH also doesn't collect info on why respondents sought mental health treatment specifically.

(23:15):

And so I would love, if it's possible, to have population-level data that tells you precisely why someone sought mental health treatment so that we could have more precise denominators. And then the other part of it, as I alluded to earlier, is that we have these huge umbrella categories for racial and ethnic groups that we're studying. And I would love to have access to more finer subgroups. And unfortunately there are going to be issues with sample size, so I hope that future studies will have the sample size to parse trends within these tinier subgroups. That would be lovely.

Lisa Dixon (23:52):

It makes me think of a project that I've been involved in, which is trying to tackle the limitations of some of these federal data sets that don't go into non-residential populations. So there's a particular project that I've been working on that tries to sample from prisons, sample from homeless shelters, and actually sample from hospitals. So we know that there's going to be an overrepresentation of people experiencing distress and mental illness in these kind of settings. And so what's going on with them and what kind of treatment are they receiving?

Navdep Kaur (24:30):

Wow, that's great.

Lisa Dixon (24:31):

So maybe you'll have access to those data fairly soon.

Navdep Kaur (24:34):

That'd be lovely.

Josh Berezin (24:34):

So what are you working on next? Besides your PhD.

Navdep Kaur (24:41):

Yeah, I would like to finish it eventually. I'm in my year three, my third year, so I finished my coursework. And so the next step is my dissertation. And so I'm shifting my focus in my dissertation. I'm obviously still interested in this mental health treatment, but I'm focusing on my home city of New York for my dissertation. So stay tuned. It's going to be wonderful, and I hope that you two would join me for my dissertation defense. That would be really lovely.

Josh Berezin (25:10):

I'll throw it on my calendar.

Navdep Kaur (25:12):

It's not going to be for a while. I don't know when it's going to happen, but it's going to happen.

Lisa Dixon (25:16):

I thought it was going to be next week.

Navdep Kaur (25:18):

Wouldn't that be wonderful? Yeah.

Josh Berezin (25:20):

Well, let me just end on one final question that gets back to the beginning of your conversation. So as you've gotten into sample sizes and measures, has your passion, when you've gotten down to the nitty-gritty, have you been able to maintain the view of it as impacting the things that got you into the work, or has that been challenging for you?

Navdep Kaur (25:49):

Honestly, it has been challenging. And it's a conversation that I have a lot with other students who are BIPOC, is what are we doing? When is this going to end? Isn't the answer obvious? Racism's there. It's something that we struggle with every day when we're doing our research. And to be honest, the passion is what keeps me going. In the acknowledgement section, I'm not sure if you noticed, there's a name there, Jonathan J. Bedmello. And that's my husband. He was born and raised in the South Bronx, he's Latinx, and he motivates me every single day to keep going. And so when I do my work, I'm thinking about him, I'm thinking about my friends, I'm thinking about my family, who all deserve equitable access to treatment. And that's what keeps me going.

Josh Berezin (26:41):

You've definitely infused me with reinvigorating my passion for some of this work as well. So it's been wonderful talking to you. And we'll see you, I don't know, 2024 for the PhD?

Navdep Kaur (26:54):

Oh my gosh, that's way too soon. I don't know.

Josh Berezin (26:57):

'25, whenever it is.

Navdep Kaur (26:58):

I'll send you an email.

Josh Berezin (26:58):

Let us know and we'll be there.

Navdep Kaur (27:00):

2030, 2040. I'm not sure.

Lisa Dixon (27:04):

Congratulations on the great work. And I hope that we have listeners who may be early in their career, and I think they'll be also drawing some inspiration from your focus. And really, thanks for sharing a little bit of your heart with us.

Navdep Kaur (27:22):

Thank you, Lisa, thank you, Josh, for having me.

Lisa Dixon (27:24):

That's it for today. We invite you to visit our website, ps.psychiatryonline.org, to read the article we discussed in this episode as well as other great research. We also welcome your feedback. Please email us at psjournal@psych.org. I'm Lisa Dixon.

Josh Berezin (27:41):

I'm Josh Berezin.

Lisa Dixon (27:42):

Thank you for listening. We'll talk to you next time.

Speaker 4 (27:46):

Join us on psychiatryonline.org/podcasts for other APA podcasts you can enjoy. In the most recent AJP audio, Dr. Stefanie Russman Block discusses the use of neuroimaging as a predictor for treatment effectiveness in patients with obsessive compulsive disorder, and AJP editor-in-chief Dr. Ned Kalin talks about how the rest of the January issue delves into neurodevelopmental disorders.

(28:04):

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