Health Care Access Alone Falling Short of Health Care Equity

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Racial-ethnic disparities in treating mental illness extend beyond differential health care access to the differential health care quality and outcomes of that care. In their article in this issue of *Psychiatric Services*, Gross et al. (1) used data from the U.S. Department of Veterans Affiars residential rehabilitation treatment program (RRTP) to examine racial disparities in posttraumatic stress disorder (PTSD) and depression outcomes among 2,870 veterans treated in the RRTP. They found a significant decrease in PTSD and depressive symptoms among veterans; however, Black veterans experienced less symptom reduction and increased symptom recurrence after discharge, compared with White veterans. Although the authors included other relevant variables in the analysis that varied between Black and White veterans (e.g., age, exposure to military sexual trauma), additional data that may inform outcome differences, such as the providers' racial-ethnic identities and the quality of the therapeutic alliance, were not collected for analysis.

Access: Only the First Step

With good reason, much of the literature on race- and ethnicity-based disparities in health care focuses on barriers to accessing treatment (2). Unfortunately, a much smaller proportion focuses on the experiences of minoritized people once health care is accessed, limiting the ability to fully understand the scope of the problem of race- and ethnicity-based health disparities. As Gross et al. (1) note, their analysis offers a unique opportunity to examine health care outcomes when access to treatment is ostensibly no longer a significant barrier, given that all veterans have access to the same medical system. That the authors found differential outcomes in this setting requires a further examination of broad and systemic issues in health care, such as clinical processes, provider training, and treatment choice, which may contribute to and reinforce disparities.

Provider Engagement of Patients in Treatment

To truly understand the experiences of Black patients in mental health settings, the nature and quality of their interactions with health care providers must be considered. Gross et al. (1) found significant differences in length of stay between Black and White veterans and noted that Black veterans may be more likely to discontinue treatment early. Although therapeutic alliance was beyond the scope of their work, the authors alluded to its role as a potential factor in these differences. Forging a strong therapeutic alliance is critical in clinical work, but it may be especially important to attend to throughout treatment with Black and other minoritized clients. Gross et al. note that some Black veterans have voiced a preference for Black therapists, and there is evidence that such a match can contribute to the formation of a strong therapeutic alliance (3). Unfortunately, this matching is often challenging to achieve given the current racial-ethnic makeup of the mental health practitioner workforce. While increasing the representation of providers with minoritized social identities is a necessary step in our field, it is also true that when a match of social identities between a provider and client is not possible, mental health providers can still work to build an effective therapeutic alliance with their clients. In doing so, providers must consider the roles that race-ethnicity and other social identities play in their own and their clients' histories and experiences—including in the treatment room (3).

Previous experiences such as discrimination, negative stereotyping, microaggressions, and cultural dissimilarity can create a "healthy cultural paranoia" among Black patients seeing White providers (4). Healthy cultural paranoia, or "cultural mistrust," can result in caution, skepticism, or a raised awareness of how Black patients are treated by White providers because of previous discrimination in a system that many Black patients may feel is not representative of their needs and was not even created to assist them (4, 5). In working to forge a stronger therapeutic alliance, healthy cultural paranoia should not be viewed as a weakness or deficit requiring an intervention or education for Black patients, but rather as an act of self-preservation and care that indicates strength and resilience. White providers can ensure positive encounters with Black patients by creating an environment where patients feel comfortable, safe,

able to trust their provider, listened to, understood, and respected (4).

Critically Evaluating Racial-Ethnic Bias

Providers can promote these supportive environments through building awareness not only of their own personal biases but also of well-documented systemic issues in the care of Black patients. Black patients of providers with higher levels of implicit bias have been found to report more negative experiences in treatment compared with White patients (5). This implicit bias can appear in various forms, such as via microaggressions, which can be especially dangerous in creating a plausible deniability where microaggressive providers have the privilege of not needing to acknowledge the hurt they've caused, power that they hold, or disparities they've created, while reinforcing a culture of discrimination toward those they work with (6).

While providers need to examine their own cultural values to reduce cultural bias toward Black patients in their interactions, treatment, and assessments, it is important to note that these internal biases are a reflection of a much larger system of oppression against Black patients (5, 6). For example, improper education on various expressions of mental illness symptoms among Black patients increases the likelihood of misdiagnosis and inequitable treatment. As reflected in the Gross et al. article (1), studies have indicated that members of minoritized racial-ethnic groups can respond differently to mental health treatments than White individuals (5). Providing equitable care, therefore, means recognizing the potentially oppressive nature of some therapy approaches and instead seeking to use culturally adapted treatments and Black American–centered therapeutic alternatives or referring clients to providers with such expertise (6).

Disparities in Mental Health Treatment Beyond Race-Ethnicity

As systems continue to reinforce race- and ethnicity-based discrimination, it is worth noting the ways that hegemony upholds other systems of power. In a recent analysis, Hunt and Adams (2) found that individuals with historically and contemporarily marginalized identities (i.e., some racial-ethnic minorities, sexual minorities, people living under the federal poverty threshold) perceived an unmet treatment need at higher rates after seeking treatment for a major depressive episode than did people without those identities or experiences. Similar to the Gross et al. findings of symptom recurrence among Black veterans, this unmet need was associated with greater impairment due to their depressive symptoms. This analysis provides further evidence that even when people with minoritized identities are able to access health care, the same systems that create barriers to access can continue to create barriers to equitable treatment and outcomes in myriad ways.

Conclusions

Gross et al.'s valuable contribution highlights the importance of addressing treatment outcomes, in addition to access issues, to understand, intervene in, and eliminate the full gamut of racial-ethnic disparities in mental health treatment. Providers and the institutions that they work for must recognize and dismantle systems that create inequity for Black patients and patients with other marginalized identities. It will take providers' ongoing commitment to recognizing their own biases and to advocating for and engaging in meaningful systemic change to make health equity a reality, rather than an aspirational ideal.

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