POLICY BRIEF

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Variation in Mental Health Care Needs and in Unmet Need for Care Among Groups of Black Adults in California

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CHIS california health interview survey

SUMMARY

KEY TAKEAWAYS

- Mental health research must disaggregate data to identify variations in mental health needs and unmet needs across the diverse groups of Black Californians.
- Multiracial Black adults have worse mental health outcomes and some have a greater unmet need for mental health services than monoracial Black adults.
- U.S.-born Black adults have worse mental health than their non–U.S.-born counterparts, but Black adults born outside the U.S. may have greater unmet need for mental health services than their U.S.-born counterparts.

To better understand the mental health needs of the Black population in California, we have used five years of pooled data (2017 to 2021) from the California Health Interview Survey (CHIS) to evaluate differences between Black adults as a single population versus Black adults as multiple populations with diverse racial and ethnic identities.

When Black adults were examined as a single group, the data showed that about 1 in 4 had either serious (13%) or moderate (10%) psychological distress (SPD/MPD); among those with SPD/MPD, 2 in 5 had unmet need for care. However, when different populations were examined separately, the data showed worse mental health outcomes among multiracial Black adults compared to monoracial Black adults, and among U.S.-born Black adults compared with their non–U.S.-born counterparts. Variation in unmet need for services was seen, from a low of 31% among Black and other race adults to a high of 59% among non–U.S.-born Black adults.

These findings emphasize the importance of looking at data by different groups to examine variations in mental health outcomes within the Black adult population. Based on these findings, our recommendations in this policy brief are to prioritize anti-racist policies that promote equity in the structural and social determinants of mental health outcomes; improve access to structurally competent mental health care; and support data disaggregation efforts to advance health equity.

"Important information is hidden when the Black adult population is examined as a single population and assumed to have the same experiences."

INTRODUCTION

Mental health is an essential aspect of overall health and well-being and includes emotional, psychological, and social well-being at every stage of life. According to the Centers for Disease Control and Prevention (CDC), 1 in 5 adults in the U.S. experiences a mental illness in a given year.[1] Although mental health conditions are experienced across all demographic groups, gaps in care vary by race and ethnicity. Mental health literature indicates that people who are Black are less likely to receive mental health care and services than those who are white, despite being more likely to experience mental health issues.[2] Research shows that racism causes stress and negatively impacts mental health outcomes for Black people.[3] Black individuals experience heightened exposure to a myriad of mental health risk factors, such as unemployment, economic insecurity, police brutality, and racial injustice.[3] As such, research should deepen our understanding of the mental health disparities, mental health needs, and unmet need for care experienced by those who are Black.

The health challenges and needs facing Black adults can vary due to the intersectionality of other racial or ethnic identities and nativity status. For example, research has found that U.S.-born adults who identify as Caribbean experience higher levels of depression compared to those who identify as African American.[4] Outdated concepts about race and the policies constructed to uphold them have created different risk factors and inequities that can influence the prevalence and distribution of psychiatric disorders in various Black populations.[5] Research exploring this possibility has grown more urgent, given that the share of Black people in the U.S. who were born elsewhere has been increasing over time: In 2019, 1 in 10 Black individuals in the country had been born outside the U.S. (10%), compared with 5% in 1990.[6]

Finally, there is also a need for more research on the mental health risk factors of multiracial Black individuals, as current (and sparse) literature suggests worse mental health outcomes and unique risk factors for this population.[7] Examining mental health outcomes through data analysis of different Black groups can offer a better understanding of the unique factors that contribute to any existing disparities. These types of analyses can also help inform the development of more culturally and contextually appropriate prevention and early intervention strategies that may prove more effective.

This policy brief uses five years of pooled data (2017–2021) from the California Health Interview Survey (CHIS) to examine mental health need and unmet need among Black adults in California. We first examined the Black adult population as a single group, and then we examined the data for differences across four racial groups: 1) Black only, 2) Black and white, 3) Black and Latinx, 4) Black and Other (which includes American Indian and Alaska Native (AIAN), Asian, Native Hawaiian/ Pacific Islander (NHPI), and other ethnic/racial groups). Lastly, we examined data between two groups based on country of birth: 1) U.S.-born Black adults, and 2) non–U.S.-born Black adults. Measures and racial groupings are described in more detail in the Data Source and Methods section.

DEFINITIONS

SERIOUS PSYCHOLOGICAL DISTRESS (SPD)

Based on the number and frequency of symptoms reported in the past year, SPD is an estimate of adults with serious, diagnosable mental health challenges, such as depression and anxiety, that warrant mental health treatment within a population.[8]

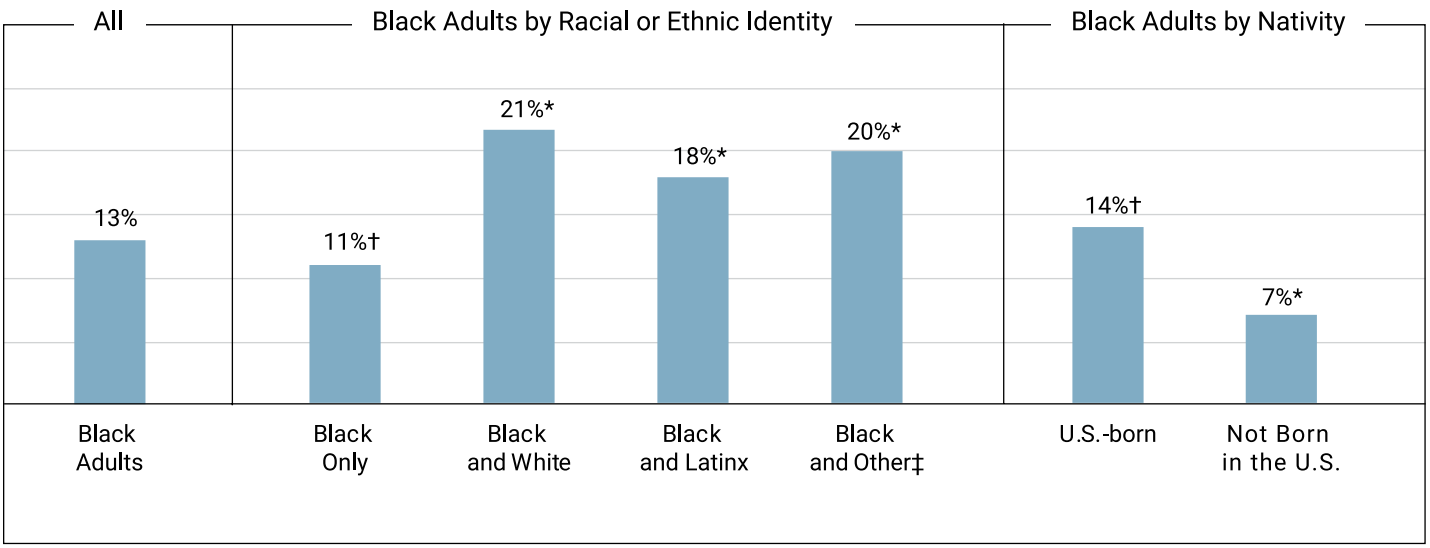
MODERATE PSYCHOLOGICAL DISTRESS (MPD)

Based on the number and frequency of symptoms reported in the past year, MPD is an estimate of adults with moderate mental distress — that is, distress that is clinically relevant and warrants mental health intervention within a population.[9]

UNMET NEED FOR MENTAL HEALTH SERVICES

Based on self-reports of not seeing a mental health or medical provider in the past year for mental or behavioral health problems among adults with SPD/MPD, unmet need is an estimate of adults with an identified need for services who did not receive the care they needed.[10]

Exhibit 1 / Percentage of Black Adults (Ages 18 and Older) With Serious Psychological Distress (SPD), California



†Reference group. *Statistically significant difference from reference group.
‡ American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, or other races or ethnicities
Source: Pooled 2017, 2018, 2019, 2020, and 2021 California Health Interview Survey

Examining Different Groups of Black Adults in California

In California, 7% of adults (2 million people) identify as Black. Within this population, a majority (76%) identify with only one racial category, and 24% identify as two or more races. The largest multiracial group is Black and Latinx (13%), followed by Black and white (3%), while 7% identify as Black and any other racial group, including American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, or "other racial group." When the authors examined the Black population by birth country, they found that 86% of Black adult Californians had been born in the U.S., and 14% had been born outside the U.S.

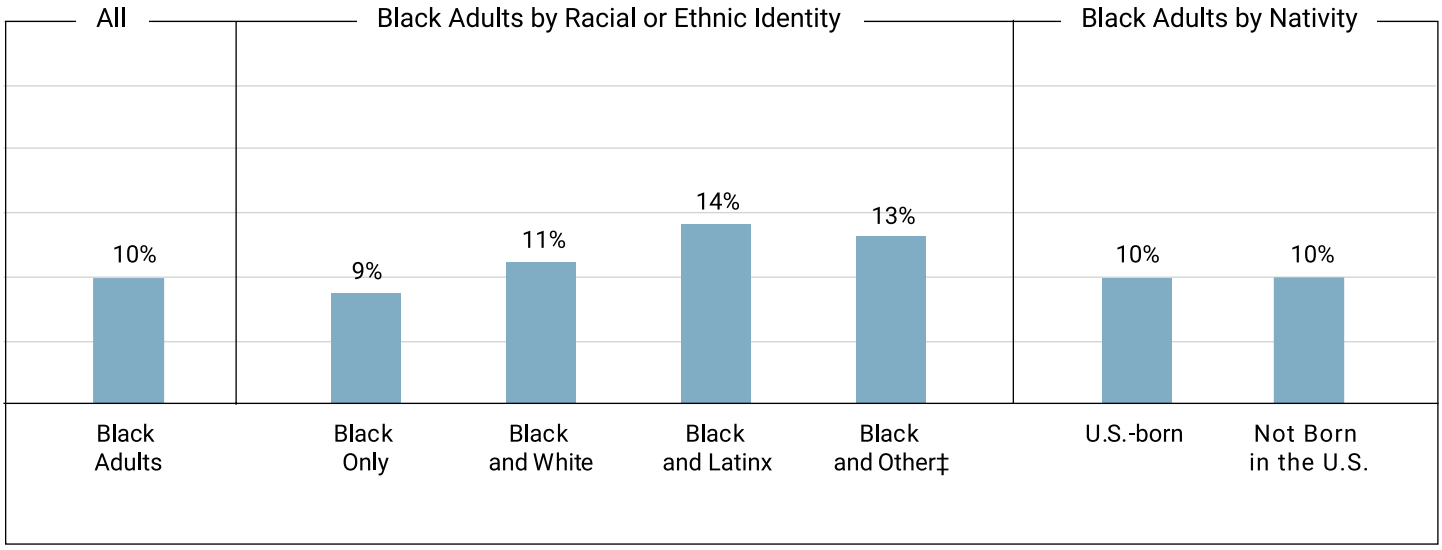
Psychological Distress Among Black Adults in California

In this section, we examine serious or moderate psychological distress (SPD/MPD), based on a person's reporting of symptoms related to depression and anxiety in the past year.

Serious Psychological Distress (SPD): Examined as a singular group, 13% of Black adults had SPD (Exhibit 1). However, when examined separately, multiracial Black adults had nearly double the rates of SPD compared to monoracial Black adults. About 1 in 5 multiracial Black adults had SPD, compared to 1 in 10 monoracial Black adults. Additionally, U.S.-born Black adults had double the percentage of SPD compared to non–U.S.-born Black adults (14% vs. 7%).

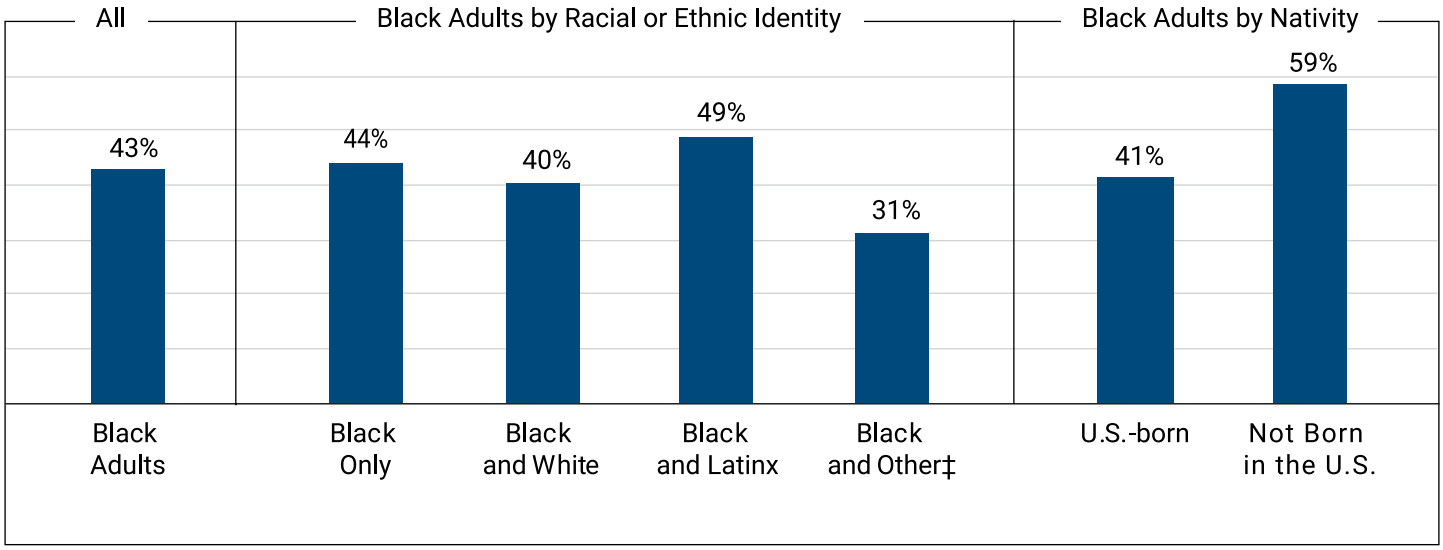
Moderate Psychological Distress (MPD): Ten percent of all Black adults had MPD. The percentage of adults with MPD ranged from 9% among monoracial Black adults to 14% among biracial Black and Latinx adults. U.S.-born and non–U.S.-born adults had similar rates of MPD (10%).

Exhibit 2 / Percentage of Black Adults (Ages 18 and Older) With Moderate Psychological Distress (MPD), California



‡ American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, or other races or ethnicities
Source: Pooled 2017, 2018, 2019, 2020, and 2021 California Health Interview Survey

Exhibit 3 / Percentage of Black Adults (Ages 18 and Older) With SPD or MPD and Unmet Need for Mental Health Services in the Past Year, California



‡ American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, or other races or ethnicities
Source: Pooled 2017, 2018, 2019, 2020, and 2021 California Health Interview Survey

Unmet Need for Mental Health Care

Unmet need is defined as having an identified need for mental health care but not receiving it. We examined unmet need among adults with SPD or MPD, which are clinically validated assessments of need.

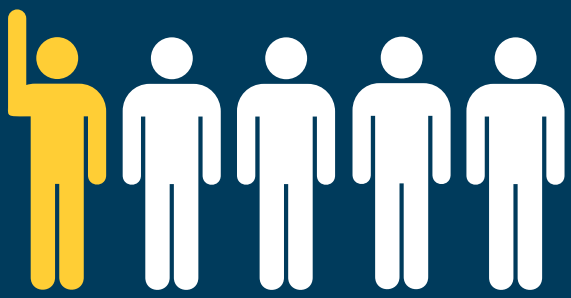
Among all Black adults with SPD or MPD, 2 in 5 (43%) had unmet need for mental health care. However, within different groups with SPD or MPD, unmet need ranged from a low of nearly 1 in 3 (31%) for Black and other race adults to nearly 1 in 2 (49%) for Black and Latinx adults. Nearly 3 in 5 (59%) similar Black adults born outside the U.S. had unmet need, compared with 2 in 5 (41%) U.S.-born Black adults (Exhibit 3).

DISCUSSION

This study highlights how important information is hidden when the Black adult population is examined as a single population and assumed to have the same experiences. Specifically, this study shows that multiracial Black adults experience worse mental health outcomes compared to their monoracial Black counterparts, and U.S.-born Black adults exhibit worse mental health than their non–U.S.-born counterparts. Furthermore, nearly half (49%) of Black and Latinx adults and more than half (59%) of non–U.S.-born Black adults had unmet need for mental health services. These findings suggest there may be unique mental health risk factors among multiracial Black adults that need further exploration, as well as unique barriers to mental health care for Black and Latinx adults and non–U.S.-born Black adults. As the multiracial and non–U.S.-born Black populations in the U.S. continue to grow, so does the need to identify variations in mental health needs and unmet need across these diverse groups. The following recommendations are aimed at improving mental well-being and access to mental health care for all groups within this diverse population.

RECOMMENDATIONS

Prioritize anti-racist policies that promote equity in structural and social determinants of mental health outcomes. Racism leads to oppression, discrimination, hate, violence, and socioeconomic inequities.[11] The pressure to identify as monoracial is just one form of racism that has impacted the mental health of minoritized racial and ethnic populations who



1 in 5

multiracial Black and white adults (21%) reported SPD, twice the percentage of adults identifying as Black only (11%).

are not monoracial.[12] Addressing the mental health risk factors and unmet needs for care among all Black subpopulations requires an anti-racist approach, one that recognizes and addresses the harm caused by institutionalized and structural racism on minoritized racial and ethnic individuals and communities. To improve the mental well-being of Black subpopulations, policymakers can consider the following recommendations:

- Develop state and local mandates requiring anti-racism training and policymaking to address political, social, and economic inequities that influence health outcomes.
- Improve the measurement of structural racism to better understand its impact on mental health outcomes.[11]

Improve access to structurally competent mental health care. Structurally competent care includes cultural competency and provides an alternative framework by redefining and building upon cultural competency in structural terms. Mental health professionals can address inequities in prevention, intervention, and treatment by being trained to recognize systemic inequities influencing mental health care and to reformulate cultural competency into structural terms and interventions, including trauma-informed care.[13,14] To ensure equitable access to mental health care for all Black subpopulations, specifically for multiracial and foreign-born Black adults, policymakers can consider the following recommendations:

- Increase multiracial and foreign-born diversity of mental health providers. Research shows that patient-to-physician racial or ethnic concordance improves patient experiences in receiving health care.[15]
- Partner with community- and faith-based organizations, community health workers, and peers with lived experience who can reach specific subpopulations, promote mental health literacy, and help bridge the gap in unmet need.

Support data disaggregation efforts that advance mental health equity. Examining Black populations as a single group masks variation among different Black subpopulations. Disaggregated data are necessary for informing equity-based policies that address the need for mental health care and the unmet need for those services among various Black populations.[16] To advance mental health equity for Black populations, policymakers can consider the following recommendations:

- Increase efforts to obtain accurate data on monoracial, biracial, and multiracial Black adults and on country of birth to help inform the investigation and reporting of disparities in mental health needs and access to care.
- Standardize disaggregated data collection, analyses, and reporting across all systems of care and support services.[17]

Data Source and Methods

This policy brief presents five years of pooled data (2017 to 2021) from the CHIS, conducted by the UCLA Center for Health Policy Research (CHPR). We used data collected in interviews with 6,204 Black adults ages 18 and older, sampled from every county in California. For our analyses, we disaggregated data by nativity status and by monoracial, biracial, and multiracial Black groups to the extent possible based on sample size and statistically stable estimates. For instance, while the pooled data provided a large enough sample size to produce statistically stable estimates for Black and white adults and for Black and Latinx adults, the sample sizes for other multiracial groups were too small and needed to be combined.

To provide a better understanding of the unique experiences of all Black adult groups, future research needs to provide further disaggregated analyses. The self-reported race variables in the CHIS were used to construct multiracial groups. SPD in the past year was defined as having a score of 13 to 24 on the Kessler-6 (K6), a validated measure designed to estimate the prevalence of diagnosable mental disorders within a population.[8] MPD in the past year was measured by using a K6 score of 9 through 12 — a clinically relevant level.[9] Unmet need for mental health services was measured using the responses to two questions: "In the past 12 months, have you seen 1) your primary care physician or 2) a mental health professional for problems with your mental health, emotions, or nerves or your use of alcohol or drugs?" A “no” response to both among those with SPD or MPD was coded as unmet need for mental health services.[10]

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CHIS california health interview survey

The California Health Interview Survey covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. It is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households. CHIS interviews were offered in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Korean, and Tagalog. CHIS is designed with complex survey methods requiring analysts to use complex survey weights in order to provide accurate variance estimates and statistical testing. CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the California Department of Health Care Services, and the Public Health Institute. For other information about CHIS, visit chis.ucla.edu.

Endnotes

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