SPA Policy Brief

Gender-, Race-, and Ethnicity-Based Discrimination in Mental Health Care: Evidence from an Audit Correspondence Field Experiment

Racial and sexual minorities may face discrimination in accessing health care, particularly mental health resources, since mental health providers have more discretion over accepting patients. Last spring, SPA Assistant Professor David Schwegman and coauthors* provided the first experimental evidence, from a correspondence audit field experiment ("simulated patients" study), of the extent of racial and gender identity discrimination in securing mental health-care appointments. The study found significant discrimination against transgender or non-binary African Americans and Hispanics, as well as that against cisgender African American women.

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MENTAL HEALTH DISPARITIES AMONG GENDER, RACIAL, AND ETHNIC MINORITIES

Transgender and non-binary (TNB) individuals experience worse outcomes for income, employment, and food security compared with cisgender individuals,[1,2,3,4] and are more likely to face mental illness and severe psychological stress, with higher rates for anxiety, depression, substance misuse, and suicidality.[5,6,7,8,9,10,11,12,13,14,] In one sample of 1,053 transgender persons, 41% reported attempting suicide—26 times higher than the general population. Around one-fourth of transgender individuals opt not to seek needed health care for fear of mistreatment due to their gender identity, and one-third report a related negative experience.

Racial and ethnic minorities face similar discrimination and disparities, especially TNB African Americans and Hispanics. The complex relationship between race, ethnicity, gender identity, and mental health has yielded conflicting evidence on the direction of mental health disparities. Transgender people, African Americans, and Hispanics are more likely to be unemployed, uninsured, exposed to neighborhood violence, and involved in the criminal justice system, creating a special category often referred to as "minority stress," which correlates with worse mental health outcomes.[15,16,17]

For transgender, African American, and Hispanic people facing psychological stressors, counseling and therapy can help address numerous mental health concerns, such as stress, anxiety, depression, and substance misuse. However, discrimination against minoritized groups, in the form of restricted access, may cause or worsen underlying race-, ethnicity-, and gender identity–related mental health disparities.[18]

TABLE 1: POSITIVE RESPONSE RATES BY GENDER IDENTITY

	Positive	Negative	Total		
Response rates by trans/cis status					
Cisgender	60.6% (291)	39.4% (189)	480		
Transgender or non-binary	52.8% (275)	47.2% (245)	520		
Total	56.6% (566)	43.4% (434)	1,000		
Test of independence, difference [*p*-value]	0.077 [0.013]				
Response rates by gender identity					
Cisgender men	61.6% (191)	38.4% (119)	310		
Cisgender women	58.8% (100)	41.2% (70)	170		
Transgender men	50.7% (71)	49.3% (69)	140		
Transgender women	55.8% (95)	44.2% (75)	170		
Non-binary	51.9% (109)	48.1% (101)	210		
Tests of independence, difference [*p*-value]	Cis men	Cis women	Trans men	Trans women	Non-binary
Cisgender men	...				
Cisgender women	0.028 [0.551]	...			
Transgender men	0.109 [0.030]	0.081 [0.154]	...		
Transgender women	0.057 [0.222]	0.029 [0.585]	−0.052 [0.365]	...	
Non-binary	0.097 [0.028]	0.069 [0.179]	−0.012 [0.828]	0.039 [0.441]	...

Note: Responses are coded as positive if the MHP's response was an appointment offer or a call or consultation offer. The *p*-values come from a t-test (two-sided). Differences are rounded to the third decimal point and computed as (positive response rate from group in column y − positive response rate from group in row x).

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TABLE 2: POSITIVE RESPONSE RATES BY RACE AND ETHNICITY

	Positive	Negative	Total
White	58.0% (290)	42.0% (210)	500
African American	55.5% (150)	45.5% (120)	270
Hispanic	54.8% (126)	45.2% (104)	230
Total	56.6% (566)	43.4% (434)	1,000

Tests of independence, difference [*p*-value]	White	African American	Hispanic
White	...	...	...
African American	−0.024 [0.514]	...	...
Hispanic	−0.032 [0.415]	0.008 [0.862]	...

Note: Responses are coded as positive if the MHP's response was an appointment offer or a call or consultation offer. The *p*-values come from a t-test (two-sided). Differences are rounded to the third decimal point and computed as (positive response rate from group in column y − positive response rate from group in row x).

THE DISCRETION OF MENTAL HEALTH CARE PROVIDERS IN THE UNITED STATES

Mental health-care providers (MHPs)––primary care physicians, psychologists, psychiatrists, nurses, mental health and substance abuse counselors, family and marriage counselors, and social workers–– supply and regulate access to mental health-care services in the U.S. Regardless of professional training and qualifications, MHPs have a significant degree of professional autonomy, specifically over which clients to accept (especially during high-demand periods). They are more likely to practice solo than other health-care providers, with fewer institutional constraints checking their explicit or implicit biases.[19,20]

Previous studies establish that health-care providers, including MHPs, make decisions about patients that are shaped by their perceptions of a patient's race, social class, and gender. For example, MHPs have been found to cultivate a group of desirable patients by "creamskimming,"[21] or choosing to provide services to a specific group of patients, based on gender or race homophily, type of service requested, or insurance status, which can also proxy for education, the likelihood and-amount of payment, and so on.

If MHP behaviors limit access to mental health services for gender, racial, and ethnic minorities, or discourage them from seeking treatment, it will worsen mental health disparities by 1) adding stress, 2) delaying treatment, which negatively impacts health and increases treatment costs, and 3) discouraging many from seeking treatment at all. Discrimination may also reduce provider-patient match quality (crucial for effective care) by forcing the patient to select a therapist who is trans-friendly but is otherwise less suitable.

THE STUDY

Using a popular website, researchers requested appointments for common mental health concerns (anxiety, depression, and stress) from U.S. mental health providers—psychologists, counselors, social workers, and psychiatrists, including transgender and non-binary individuals. Appointment request emails included randomly-assigned names to signal race or ethnicity (African American, Hispanic, or White). Each MHP received one inquiry from one prospective patient who disclosed that they are transgender (25% of the time), non-binary (25%), or undisclosed—presumed cisgender (50%). Discrimination was quantified by comparing the MHP positive response rates (appointment, consultation, or phone call offer) by patient gender identity, race, and ethnicity. MHPs had the options of responding via email, phone (or voicemail), or text message; their response was coded to one of seven mutually exclusive outcome categories: appointment offered, call or consultation offer, screening question(s) (e.g., can you pay out of pocket?), referral, waitlist, rejection, and no response.

RESULTS

They received nonautomated responses to 75.5% of inquiries, and a positive response—either an appointment offer (33.3%) or a call or consultation (23.3%)—for 56.6% of inquiries.They received no response 24.5% of the time, by far the most common negative response.

The study found that African American and Hispanic transgender and non-binary people face discrimination when attempting to access mental health-care services, though White transgender and non-binary prospective patients do not. It could not determine whether cisgender African American or Hispanic prospective patients face discrimination. There was no evidence of discrimination against White transgender and nonbinary individuals, and it is unclear whether (presumed) cisgender African American or Hispanic patients face discrimination in access to appointments relative to their White and cisgender counterparts. Further, cisgender African American women face discrimination relative to cisgender White women and cisgender African American men.

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POLICY IMPLICATIONS AND RECOMMENDATIONS

These findings inform discussions around oversight and regulation of the mental health-care markets, which occurs through federal and state anti-discrimination laws, state licensing regulations, and professional association policies. Second, they speak to the undersupply of LGBTQ1-competent MHPs and African American and Hispanic MHPs, and can guide conversations around diversifying the profession and improving training. Third, research on discriminatory barriers faced by transgender and racially diverse people in access to mental health care is increasingly relevant, as many governments, particularly those in the United States, are aggressively proposing and passing anti-LGBTQ1 legislation that could negatively affect mental health and reduce access to health care.

CONCLUSION

MHPs are less likely to offer appointments or respond to African American or Hispanic transgender and non-binary (TNB) prospective patients, a big problem given the mental health disparities faced by TNB individuals, African Americans, and Hispanics, and particularly, TNB African Americans and Hispanics. Given that these minoritized groups are, on average, in greater need for mental health services, discrimination by MHPs can have profound mental and physical health consequences.

KEY FINDINGS

- Cisgender "patients" received a positive response 60.6% of the time while TNB prospective patients received a positive response only 52.8% of the time—a 7.8% difference.
- Cisgender men got the highest positive response rate (61.6%), followed by cisgender women (58.8), transgender women (55.8), non-binary people (51.9), and transgender men (50.7).
- White patients had the highest positive response rate (58.0%), followed by African Americans (55.5) and Hispanics (54.8).
- Cisgender prospective patients have a higher response rate compared with their TNB counterparts of the same race or ethnicity: cisgender African Americans have a higher positive response rate (60.7%) than TNB African Americans (50.0%) and cisgender Whites have a higher positive response rate (61.5%) than TNB Whites (54.2%).
- TNB African Americans got the lowest positive response rate (50.0%) compared with cisgender Whites (61.5%) and TNB Hispanics (53.3%), suggesting an intersectional effect.
- Prospective patients who signal transgender or nonbinary status have a 6.5 -7.5% lower positive response rate, with no differences between White, African American, and Hispanic patients.
- There was no evidence of differential positive response rates between cisgender-assumed patients and those who directly signal TNB status. MHPs are, however, significantly less likely to respond to African Americans (13.3%) and or Hispanics (13%).
- The evidence of intersectional discrimination was inconclusive as to the existence of racial and ethnic discrimination against cisgender prospective patients.
- Results showed a 9.8% higher positive response rate for cisgender African American men and a 13.1% lower positive response rate for cisgender African American women.
- Cisgender African American women face more discrimination relative to cisgender African American men and cisgender White women.
- Heightened discrimination against African American and Hispanic TNB prospective patients is robust to the inclusion of controls for state-level COVID-19 intensity.

LIMITATIONS

• These should be considered the most conservative estimates of discrimination in access to mental health care. The design of this experiment detected discrimination only at the earliest point in the continuum of mental health care: the first point of contact with an MHP.

• Discrimination may also occur, for example, in diagnosis, billing, or treatment. Future work should consider these possible vectors of discrimination for a more comprehensive view of the barriers to mental health access faced by minoritized groups.

Endnotes

1 Grant, J.M., Mottet, L.A., Tanis, J. Harrison, J., Herman, J.L., & Keisling, M. (2011.) Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington National Center for Transgender Equality and National Gay and Lesbian Task Force. https://www.thetaskforce.org/wp-content/uploads/2019/07
/ntds_full.pdf.

2 Carpenter, C.S., Eppink, S. & Gonzales, G. (2020.) Transgender Status, Gender Identity, and Socioeconomic Outcomes in the United States. ILR Review 73(3): 573–99. https://doi.org/10.1177/0019793920902776

3 Badgett, M.V.L., Carpenter, C.S., & Sansone, D. (2021). LGBTQ Economics. Journal of Economic Perspectives 35(2): 141–70. https://doi.org/10.1257/jep.35.2.141.

4 Liszewski, W., Peebles, J.K., Yeung, H., Arron, S. (2018.) Persons of Nonbinary Gender—Awareness, Visibility, and Health Disparities. New England Journal of Medicine 379(25): 2391–93. https://doi.org/10.1056/NEJMp1812005.

5 Streed, C.G., McCarthy, E.P, & Haas, J.S. (2018.) Self-Reported Physical and Mental Health of Gender Nonconforming Transgender Adults in the United States. LGBT Health 5(7): 443–48. https://doi.org/10.1089/lgbt.2017.0275.

6 Mustanski, B.S., Garofalo, R., & Emerson, E.M. (2010.) Mental Health Disorders, Psychological Distress, and Suicidality in a Diverse Sample of Lesbian, Gay, Bisexual, and Transgender Youths. American Journal of Public Health 100(12): 2426–32. https://doi.org/10.2105/AJPH.2009.178319.

7 Su, D., Irwin, J.A., Fisher, C., Ramos, A., Kelley, M., Mendoza, D.A.R., & Coleman, J.D. (2016.) Mental Health Disparities within the LGBT Population: A Comparison between Transgender and Nontransgender Individuals. Transgender Health 1(1): 12–20. https://doi.org/10.1089/trgh.2015.0001.

8 Feir, D., & Mann, S. (2024.) Temporal Trends in Mental Health in the United States by Gender Identity, 2014–2021. American Journal of Public Health. Published ahead of print, February 29, 2024, e1–4.

9 Lagos, D. (2018.) Looking at Population Health Beyond 'Male' and 'Female': Implications of Transgender Identity and Gender Nonconformity for Population Health. Demography 55(6): 2097–117. https://doi.org/10.1007/s13524-018-0714-3.

10 Meyer, I.H., Brown, T.N.T., Herman, J.L., Reisner, S.L., & Bockting, W.O. (2017.) Demographic Characteristics and Health Status of Transgender Adults in Select US Regions: Behavioral Risk Factor Surveillance System, 2014. American Journal of Public Health 107(4): 582–89. https://doi.org/10.2105/AJPH.2016.303648.

11 Safer, J.D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016.) Barriers to Healthcare for Transgender Individuals. Current Opinion in Endocrinology, Diabetes, and Obesity 23(2): 168–71. https://doi.org/10.1097%2FMED.0000000000000227.

12 James, S.E., Herman, J.L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016.) The Report of the 2015 US Transgender Survey. National Center for Transgender Equality. http://www.ustranssurvey.org/reports.

13 Miranda, J., McGuire, T.G., Williams, D.R., & Wang, P. (2008.) Mental Health in the Context of Health Disparities. American Journal of Psychiatry 165(9): 1102–8. https://doi.org/10.1176/appi.ajp.2008.08030333.

14 Williams, D.R. (2018.) Stress and the Mental Health of Populations of Color: Advancing Our Understanding of Race-Related Stressors. Journal of Health and Social Behavior 59(4): 466–86. https://doi.org/10.1177/0022146518814251.

15 Seng, J. S., Lopez, W.D., Sperlich, M., Hamama, L., & Meldrum, C.D.R. (2012.) Marginalized Identities, Discrimination Burden, and Mental Health: Empirical Exploration of an Interpersonal-Level Approach to Modeling Intersectionality. Social Science and Medicine.

16 Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. PLOS ONE 10(9): e0138511. https://doi.org/10.1371/journal.pone.0138511.

17 Lambda Legal. (2010.) When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination against LGBT People and People Living with HIV. Lambda Legal. http://www.lambdalegal.org/health-care-report.75 (12): 2437–45.

18 Himelhoch, S., Weller, W.E., Wu, A.W., Anderson, G.F., & Cooper, L.A. (2004). Chronic Medical Illness, Depression, and Use of Acute Medical Services among Medicare Beneficiaries. Medical Care 42(6): 512–21. https://doi.org/10.1097/01.mlr.0000127998.89246.ef.

19 Kane, C.K., & Emmons, D.W. (2013). New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts toward Hospital Employment. American Medical Association. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf.

20 Michalski, D., Mulvey, T., & Kohout, J. (2010.) 2008 APA Survey of Psychology Health Service Providers. American Psychological Association Center for Workforce Studies. https://www.apa.org/workforce/publications/08-hsp.

21 Teasdale, A.C., & Hill, C.E. (2006). Preference of Therapists-in-Training for Client Characteristics. Psychotherapy: Theory, Research, Practice, Training 43(1): 111–18. https://doi.org/10.1037/0033-3204.43.1.111.