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EDITORIAL

Introduction to the Special Issue on Health Disparities and Diversity

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While health disparities in the US have existed for more than a century (Krieger & Fee, 1996), racial and ethnic health disparity gaps have grown wider (Srinivasan & Williams, 2014). More than 30 years ago, the U.S. Department of Health and Human Services Task Force Report on Black and Minority Health was released, which elevated concerns about the poor health of racial and ethnic minority groups in the U.S. health policy agenda (US-DHHS, 1985; Kumanyika & Morssink, 2006). Almost 20 years ago, the then US Surgeon General, Dr. David Satcher, in *Healthy People 2010*, announced the audacious goal of eliminating such health disparities by the year 2010 (US-DHHS, 2000). Throughout this time, there remains the sense that the problem of health disparities is constantly being rediscovered, but that actual progress toward the elimination of gaps in health outcomes has been slow (Kumanyika & Morssink, 2006; Srinivasan & Williams, 2014).

The definition of health disparities has expanded from "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States" in *Healthy People 2010*, to a more complex and nuanced statement, which recognizes that "Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" in *Healthy People 2020* (US-DHHS, 2010). Initially, "health disparities" was synonymous with racial and ethnic health disparities, but modifiable, unjust differences in health exist on dimensions other than race and ethnicity. Research focusing only on race and ethnicity does not provide a complete picture of the determinants of health disparities (Kawachi, Daniels, & Robinson, 2005; Srinivasan & Williams, 2014).

In this context, Dr. Barbara Cubic, the then President of the Association of Psychologists in Academic Health Centers (APAHC), created a task force to examine and address issues pertinent to psychologists related to such health disparities. She reached out to Guest Editor Dr. Breland-Noble to serve as Chair for a Task Force on Health Disparities and Diversity; thus, the task force was born. The Task Force "values the unique strengths and abilities of all persons and seeks to support their behavioral and emotional health." In addition, the Task Force "works to increase the provision of research-informed care that reflects the needs and concerns of diverse populations to help eliminate disparities and promote behavioral and emotional health among different groups." Over time, the Task Force became a standing committee of APAHC, the APAHC's Committee on Health Disparities and Diversity. The Committee's mission is to a) support APAHC in maintaining an equitable environment for diverse psychologists in Academic Health Centers (AHC); b) ensure that issues of diversity in race, gender, sexual orientation, and ability status remain central to the mission of APAHC; c) foster discussion among AHC psychologists on research, clinical care, and policy related to health disparities in behavioral health and academic medicine; d) promote research on

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training models and clinical care to address health disparities; e) support skill development and mentorship attainment in areas relevant to diversity (broadly defined) among early career psychologists and trainees; and f) implement targeted training programs for providers, researchers, and administrators.

There remain significant challenges with describing and understanding the mechanisms and pathways through which race and ethnicity have been effective proxies for poor health outcomes and for determining who needs additional resources and attention (Dressler, Oths, & Gravlee, 2005; Ford & Harawa, 2010; LaVeist, 1995, 2000; Diez Roux, 2012). This is particularly true of mental and behavioral health disparities because they often do not follow the same patterns as physical health disparities (Jackson & Knight, 2006). For example, since the 1980s, psychiatric epidemiologic studies have documented that White Americans have higher rates of depression and anxiety than Black Americans (Mezuk, Abdou, Hudson, Kershaw, Rafferty, Lee, & Jackson, 2013). Thus, there may be some instances in which nonminority populations experience higher rates of mental illness than minority populations.

Explanations for these patterns have proven elusive, and the volume of literature describing health disparities and discussing strategies to eliminate health disparities remains plagued with confusion about the differences between "minority health promotion" and "health disparities elimination." While both outcomes are important and deserve attention, it is likely that each may have somewhat different determinants and call for different intervention strategies. Furthermore, the comparative approach that is the cornerstone of health disparities research provides critical insight to some areas while obscuring others (Griffith & Bediako, 2007). In this context, one of the biggest challenges has remained, how do we provide optimal mental health care that meets the dual goals stated in *Healthy People 2010*: increasing the years and quality of life for all Americans while reducing and working toward the elimination of health disparities. Looking forward, attaining these dual goals requires attention to issues such as: equitable access to care; innovative approaches to reducing disparities (e.g., community-based participatory research [CBPR], community-located services, integrated care); and interventions for treating disparities in mental health, e.g., adapted treatments that have demonstrated efficacy in racially diverse populations.

In the opening commentary, "Promoting mental health equity: The role of integrated care," former Surgeon General David Satcher and Sharon Rachel describe the historical context of the landmark report, *Mental Health: A Report of the Surgeon General*, which highlighted that few people with a diagnosable mental disorder were receiving care. Satcher and Rachel argue that integrating mental and behavioral health into primary care could help to not only increase access to care but reduce health disparities.

Additional articles for this special section document the importance of health disparities research. The articles also highlight the contributions of psychologists who do such research, and those of psychologists whose work as clinical providers and health services administrators contributes to reducing health disparities.

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Compliance with Ethical Standards

Conflict of interest Alfiee M. Breland-Noble and Derek MacGregor Griffith declare that they have no conflict of interest.

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