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Journal

European Urology Focus, 6(6)

ISSN

2405-4569

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Publication Date

2020-11-01

DOI

10.1016/j.euf.2019.08.017

Peer reviewed

Published in final edited form as:

Eur Urol Focus. 2020 November 15; 6(6): 1155–1157. doi:10.1016/j.euf.2019.08.017.

What is the Impact of Racial Disparities on Diagnosis and Receipt of Appropriate Mental Health Care Among Urology Patients?

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Keywords

mental health; genitourinary cancer; disparity; depression

Introduction

Disparities arising from disadvantages and inadequacies in healthcare access, infrastructure, utilization, and quality continue to disproportionately expose vulnerable populations to differences in medical and mental health services overall [1]. Disparities in access to mental health services and psychotropic medication use have worsened over time in minority populations, with rates of access for minority patients being roughly half that of white patients after adjusting for clinical need [2]. Concomitantly, minority patients who seek mental health services have a greater risk of overdiagnosis of severe mental illness, demonstrate lower rates of initial treatment utilization, and have worse quality of care (i.e., over-utilization of older psychiatric medications). In addition, sociocultural factors such as stigma, mistrust in the healthcare system, familial support, spirituality, and cultural beliefs further impact treatment engagement and attrition [3].

While ongoing efforts have focused broadly on documenting and addressing racial disparities in mental healthcare, less is known about the complex interplay between race and mental health in urologic patients. We aim to review the current, and albeit limited, literature available on racial disparities in the diagnosis and receipt of appropriate mental healthcare among patients with urologic diagnoses.

Mental health and non-oncologic urologic disease

The severity and treatment response of several benign urologic diseases are closely linked with mental health. These are largely described in patients with lower urinary tract

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symptoms such as overactive bladder (OAB) and chronic pelvic pain syndrome (CPPS). These chronic conditions have been shown to associated with increased rates of affective symptoms such as depression and anxiety, while also exacerbating pre-existing mental health impairments. [4,5]

OAB is often associated with increased rates of depression, anxiety, and negative psychological symptoms. In addition, OAB has been shown to be independently associated with impairments in sexual quality of life. Interestingly, recent focus on gender-based differences has demonstrated that OAB is more prevalent in women while men are more likely to report a negative impact on their daily activity and anxiety related to the diagnosis. Depression did not differ significantly between genders [4]. Although there is increasing emphasis on the differential impact of OAB by gender, little is known about its impact in minority populations and how interactions between race and gender alter the presentation and treatment response of OAB.

In patients with CPPS, psychosocial factors such as illness-focused coping (guarding, resting, and asking for assistance) can significantly alter the relationship between somatic pain and mental health quality of life. In a similar fashion, depression and catastrophizing have been found to have a strong negative impact on mental quality of life [5]. The social impact of these conditions including social stigma and feelings of isolation serve to intensify the negative influence of affective symptoms while also increasing the risk for disengagement from treatment. [3]

Genitourinary malignancies in the context of mental health

The relationship between cancer and mental health is bi-directional: a pre-existing mental health diagnosis may significantly impact cancer care, and new posttreatment psychiatric diagnoses such as anxiety, depression, or suicidality may arise in those receiving cancer treatments.

Prior work has shown that a new cancer diagnosis may increase the risk of death from suicide up to 60% (HR 1.60, 95% CI, 1.42-1.81) within the first 50 months after diagnosis. This risk increases significantly for patients with minimal psychiatric care utilization prior to diagnosis and with stage IV disease (HR, 4.41; 95% CI, 3.05-6.33) [6]. For patients with genitourinary malignancies, an increased risk of suicide ranging from 7% to 73—prostate, HR 1.07, 95% CI 0.90-1.27; kidney, HR 1.26, 95% CI 0.79-2.02; bladder, HR 1.73, 95% CI 1.14-2.62—compared to matched noncancer controls. In the case of muscle-invasive bladder cancer, a pre-existing psychiatric illness has been associated with decreased odds of guidelines-based treatment such as radical cystectomy or trimodal therapy [severe mental illness, OR 0.55, 95% CI 0.37-0.81; depression, OR 0.71, 95% CI 0.58-0.88], leading to worse survival outcomes [7]. Conversely, in long-term survivors of prostate cancer, new clinically relevant mental health symptoms were more frequent compared to the general population (14% vs 6%, $p<0.001$) [8].

Given the well described disparities in genitourinary cancer access and outcomes, it is important to evaluate the impact that mental health on treatment choice, quality of life/

survivorship, and oncologic outcomes among minority patients. In order to better understand and appropriately treat mental health issues as they arise, there is an increasing need for further examination of the issues surrounding mental health in genitourinary cancer, particularly in communities of color. More granular qualitative assessments of the mental health needs of patient receiving oncologic care would provide both insight and hypothesis-generating opportunities for future research. In addition, prospective studies utilizing mixed methodology with validated mental health-focused instruments and quantitative interviews may aid in more comprehensive characterization of mental health burden in minority populations with urologic diseases.

Reducing disparities: Opportunities for intervention

Numerous studies have highlighted the increasing need for screening for distress, depression, anxiety, depression, and suicidal ideation with appropriate referrals to psychiatric services for those dealing with a new diagnosis [6]. The influence of social determinants of health on outcomes remain conserved across numerous domains, including mental health and oncologic outcomes. Factors such as poverty remain intimately tied to one's ability to access medical and community-based resources. [3]

In order to treat the whole patient, we cannot ignore the mental health implications of a new urologic diagnosis. But this requires a multi-disciplinary approach to better manage the depression, anxiety, fear, and other factors which may arise from or be exacerbated by a new urologic diagnosis. This remains particularly true for patients dealing with a chronic condition or a new cancer diagnosis. Certain healthcare models such as Accountable Care Organization may incentive improvements healthcare systems, thereby reducing disparities as a result. [9] Yet this paradigm is even more elusive for those with limited resources or access to healthcare, let alone access to specialized mental health services and psychosocial support. At this time there continues to be a need to develop strategies to assess and the impact of the complex relationship between racial disparities and mental health factors in urologic disease.

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