Reducing Disparities

## Ethnic Minorities and Mental Health

THE SIXTEENTH ANNUAL ROSALYNN CARTER SYMPOSIUM
ON MENTAL HEALTH POLICY

Native Americans and Alaska Natives suffer dispro-portionally from depression and substance abuse. They are also overly represented in inpatient care.
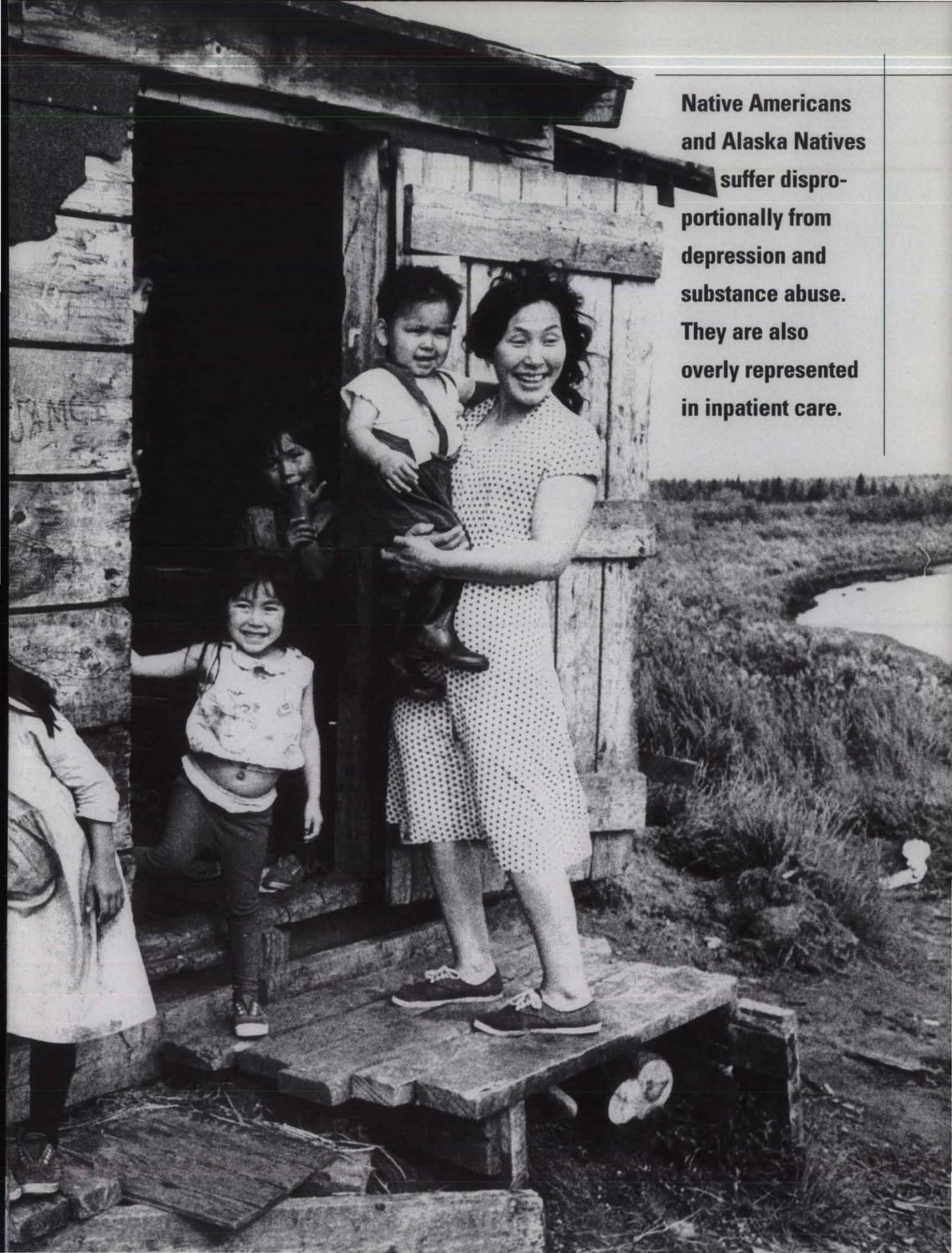
"Minority children ... are much less likely than Whites to get the help they need and much more likely than Whites to be trapped into a system from which many never return. This represents not only a loss of freedom, but also a loss of tremendous human potential."

— David Satcher, Surgeon General

More than 43 million Americans lack access to our system, including 11 million children. Many of them are ethnic Americans.
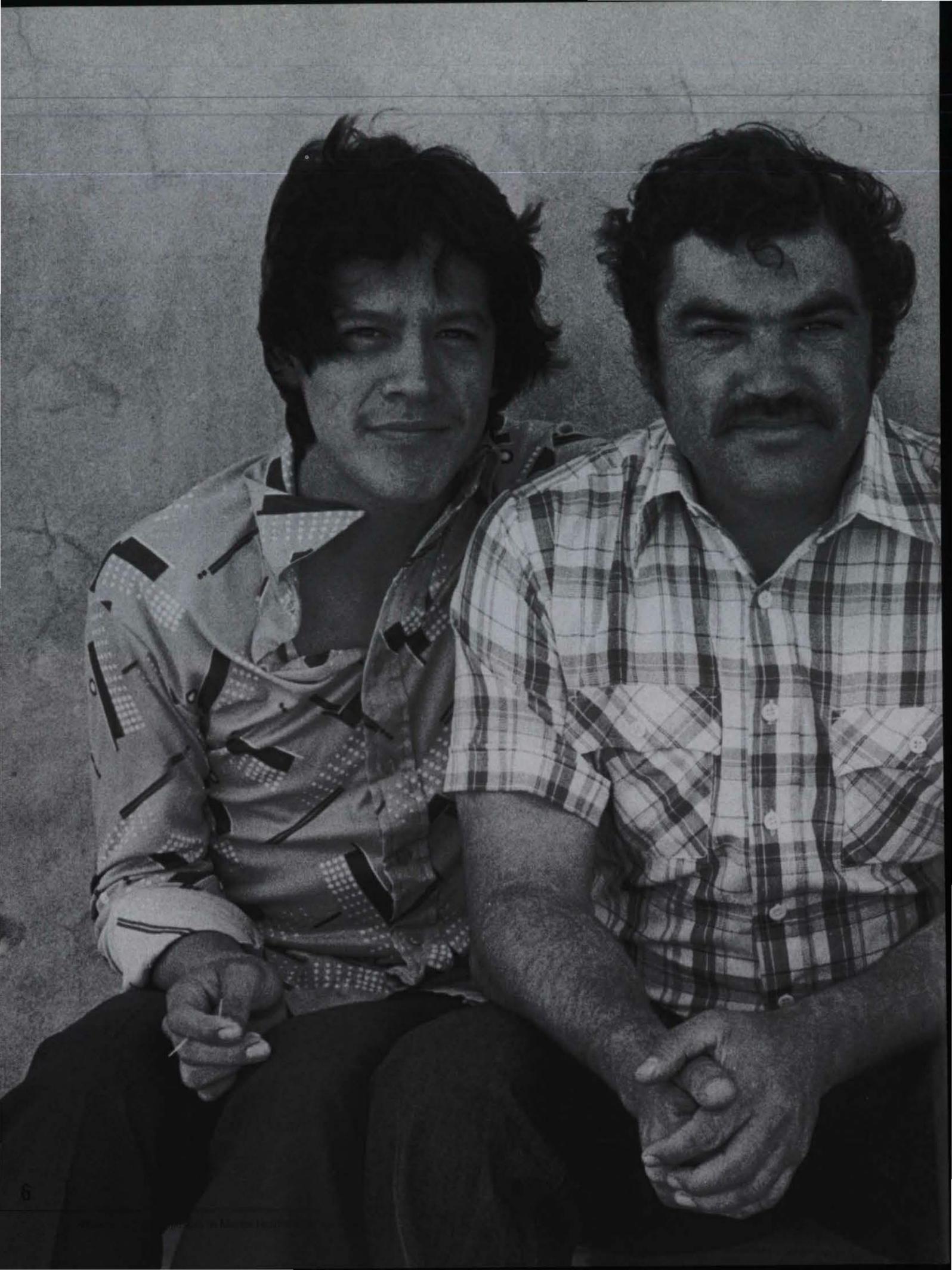
Basic problems with our system disproportionately impact ethnic and racial minorities. One out of three Hispanic Americans is uninsured. Nearly half of all Hispanic Americans do not have a personal physician.
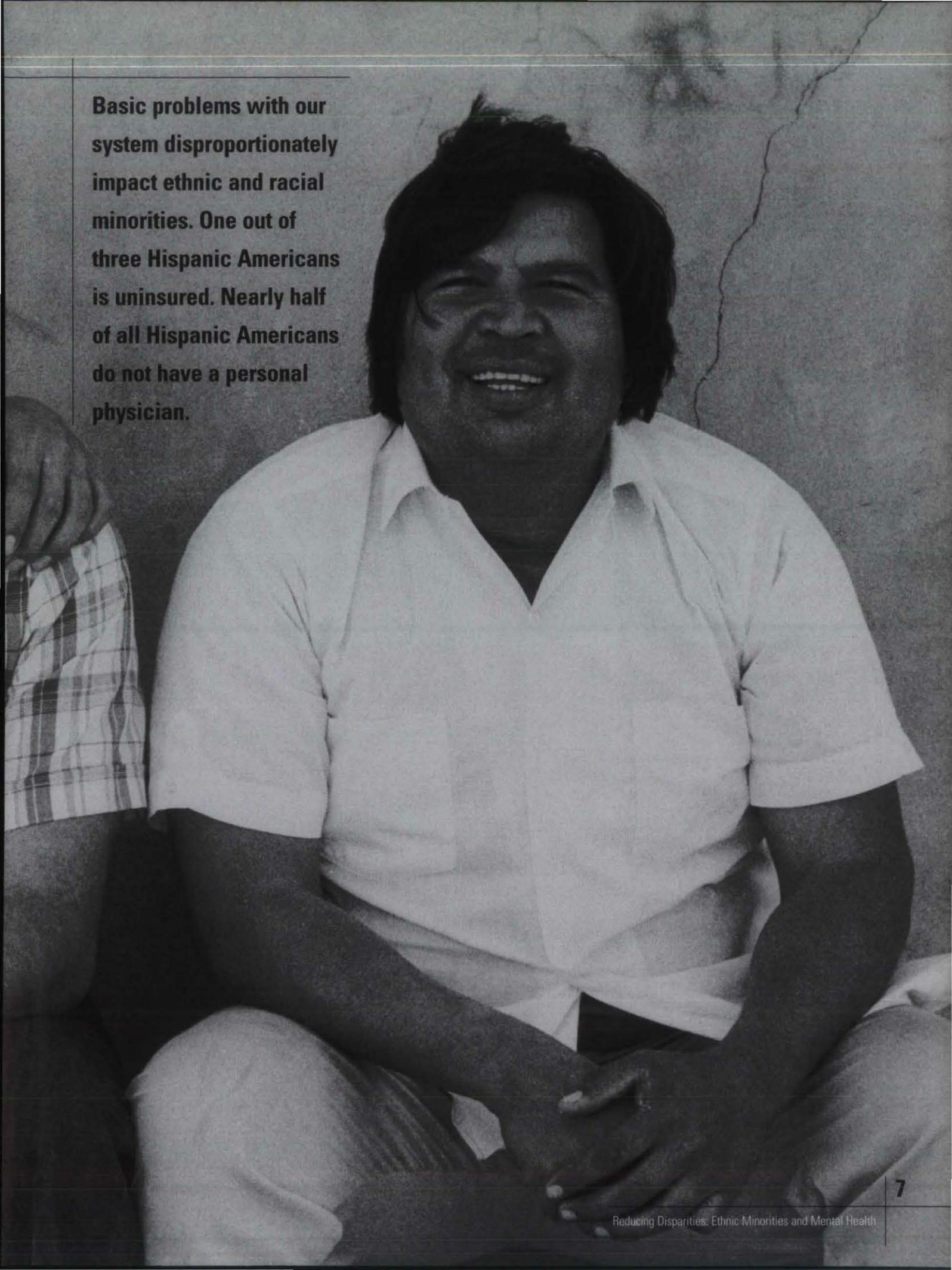
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ON MENTAL HEALTH POLICY

November 8 and 9, 2000

Former First Lady Rosalynn Carter is chair of The Carter Center Mental Health Task Force.

Equity of Access

A time to act, a time to reach out to all people.

Rosalynn Carter

This year's topic is a continuation of our series of symposia highlighting the first-ever report of a United States Surgeon General on mental health. We will address the Surgeon General's supplemental report on ethnic minorities in mental health to be released very soon.

We at The Carter Center are working to focus attention on these reports and to educate the public about the facts of mental health and mental illnesses. Many organizations are doing the same—but there is still so much to be done to integrate our message into American life.

We all know that if negative attitudes regarding mental illnesses are a problem for Americans in general, they are an even greater problem for racial, ethnic, and cultural minorities. A recent survey reveals a lack of public awareness about the serious gaps in healthcare between minority populations and white Americans. We must try and increase public awareness of these gaps and play a role in finding some possible solutions for closing them. This Surgeon General's report has given us a great opportunity to do that.

We want the report to extend to everyone in our society. We want to help reduce the stigma faced by those who suffer from mental illnesses but also are discriminated against based on their status as minorities. To succeed and increase the number of people in these communities who receive treatment, we have to involve the media. All of us advocates are responsible for getting out the message of this supplemental report.

We are going to identify some specific ways to incorporate the report into our own activities in order to eliminate the stigma and discrimination and make mental health care equally accessible to everyone.

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Golden Opportunities

Despite our knowledge gaps, we know there are no unsolvable problems.

ADM David Satcher
United States Surgeon General

Adm. David Satcher, M.D., Ph.D., a physician, scholar, and lifelong public health advocate, is the 16th Surgeon General of the United States and the Assistant Secretary for Health. He served as director of the Centers for Disease Control and Prevention from 1993 until becoming Surgeon General in 1998. Previously, Dr. Satcher was president of Meharry Medical College, professor and chairman of the Department of Community Medicine and Family Practice at the Morehouse School of Medicine, and a former faculty member of the UCLA School of Medicine and the King-Drew Medical Center in Los Angeles. A native of Alabama, Dr. Satcher graduated from Morehouse College. He received his M.D. and Ph.D. from Case Western Reserve University, where he was elected to the Alpha Omega Alpha Medical Honor Society.

We have come a long way with regard to mental health. When I think of all of the work that has taken place, especially over the past 25 to 30 years—all of the research, all of the science —I think the Surgeon General's report offers a message of hope. It says we have an attainable goal that depends on us, together, addressing the problem of stigma, the lack of parity of access, and the other issues that have made it so difficult to deal with mental health problems in this country. But getting to a point of parity and overcoming stigma, as you know, will be very difficult. That is why I want to focus on what we have to do, especially related to mental health improvements for ethnic, racial, and cultural minorities.

Tradition and Example

There is a principle in the Public Health Service that dates back to 1798 when President John Adams signed the Congressional act that created the Marine Hospital Service, the predecessor of the Public Health Service.

The Marine Hospital Service was established in response to the risk merchant seamen faced of contracting illnesses as a result of their work. When they became ill,

often from infectious diseases, it was not just a problem for the seamen, it also threatened to affect their families and their communities. In 1793, for example, one of the worst epidemics in our nation's history—the yellow fever outbreak in Philadelphia, resulting from infected seamen—wiped out 10-20 percent of the population, while another 50 percent fled the city.

The establishment of the Marine Hospital Service was based on a principle that to the extent that we meet the health needs of the most vulnerable among us, we actually do the most to promote and protect the health of the nation. Whether we're talking about children or ethnic minorities, the extent to which we respond to the needs of our most vulnerable citizens and the degree to which we make changes to alleviate the unique needs of our least protected says a great deal about how well we are promoting and protecting the health of the nation.

In that spirit, I approach this task: to deal with mental health issues related to ethnic and racial minorities.

Fundamental to Wellness

The Mental Health report makes its points well. If the American people get its messages, and if we, as a nation,

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respond to them, significant and lasting changes will result. The report says that mental health is fundamental to overall health and well-being. You cannot be healthy without mental health. The report says that mental illness is very real. In fact, one in five people in this nation experiences a mental disorder each year. The report says it is not appropriate to separate mental disorders and physical disorders: mental disorders are physical disorders. That statement is based on the best available science in studies of the brain. The more we learn about the brain, the better able we are to treat mental disorders.

Further, the good news in the report is that 80-90 percent of the time, we can treat people with mental disorders and return them to productive lives and positive relationships. And that is our definition of mental health: the ability to carry out productive mental functions, the ability to establish and maintain positive relationships, the ability to deal with adversity, and the ability to adapt to changes in one's environment.

The report's bad news is that less than half of the people who experience a mental illness in any given year seek treatment. Less than one-third of children who need treatment for mental disorders receive it.

The report discusses reasons for this failure: the stigma that keeps people from seeking help and the barriers in the system that limit access to care.

Access for All, Equity for All

The disparities in mental health services constitute unique challenges for African Americans, Hispanic Americans, Asian Americans, and Native Americans. But the report did not deal adequately with these inequities, so one of its first supplements deals with mental health as it impacts racial and ethnic minorities and cultural issues.

It is common knowledge, at least among professionals in the field, that we have major access problems in this country when it comes to health care. We spend more than $1.3 trillion a year for health care—more than any other nation in the world—and we spend more per capita than any other nation. Yet the World Health Organization's *Year 2000 Report on Health Systems* ranks the United States number 37 in terms of health system performance efficiency. Two factors led to that low ranking.

First, more than 43 million Americans are uninsured and lack access to our system, including 11 million children.

Second, our system lacks balance in terms of health promotion, disease prevention, early detection, and universal access to quality care. WHO's report went on to point out that the United States invests less than two percent of its healthcare expenditures in population-based prevention of America's major killers.

Furthermore, these basic problems with our system disproportionately impact ethnic and racial minorities. One out of three Hispanic Americans is uninsured. Nearly half of all Hispanic Americans do not have a personal physician. One out of four African Americans is uninsured; 36 percent do not have a personal physician.

Among the elderly, thousands do not have access to prescription drugs and decent meals. The mental/physical health disparity is pronounced here, too. In Medicare, an outpatient treatment for a physical illness requires a 20 percent co-payment, but if it involves a mental illness, the law requires a 50 percent co-payment.

But being insured is no guarantee of access to quality care, because there are many people who are insured but their benefits are not adequate to meet their healthcare needs. According to the report, there

Twenty percent of children and adolescents experience a mental disorder each year, yet only about one-third of those who need mental health services get them.

are specific problems with Medicare, Medicaid, income supports, housing, and managed care.

Need for a New Truck

There is the story of the Texas farmer who was visiting South Carolina. This Texas farmer was proud of his 5,000-acre farm. While visiting a fellow farmer in South Carolina, he said, "Sir, how many acres do you have here?"

The South Carolina farmer said, "I have about 40 or 50 acres."

The Texas farmer thought to himself, "My goodness, my farm is so big, this guy could hardly comprehend the size." So he gave this example. He said, "Here's how big my farm is. When I get up in the morning just as the sun is coming up, I get in my truck and drive across my farm. And when the sun is going down in the evening, I still have not reached the end of my farm."

The South Carolina farmer thought about that a minute and said, "You know, I used to have a truck like that."

There's nothing wrong with the size of our health system, but there is something wrong with our truck. There are basic issues we must correct.

Unequal Treatment

The Surgeon General's mental health report points out that disparities abound in treatment utilization. In general, persons from minority groups are less likely than Whites to seek outpatient treatment. They also are more likely to have access problems related to being uninsured, under-insured, and living in underserved communities. Estimates show that African Americans are much more likely to be seen as inpatients than outpatients; in fact, they are much more likely to end up in the emergency room for a mental disorder as opposed to seeking outpatient care. When they do

seek care they are more likely to need inpatient treatment.

In the report, we say the rate of mental illness among Hispanic Americans tends to be similar to that among Whites. Hispanic American women are more likely to suffer depression than Hispanic American men. Asian Americans and Pacific Islanders are only 25 percent as likely as Whites, and only half as likely as African Americans and Hispanic Americans, to seek outpatient care. They are less likely than Whites to receive inpatient care, and when they do seek care, they are more likely to be misdiagnosed as "problem-free." Native Americans and Alaska Natives suffer disproportionally from depression and substance abuse. Native Americans also are overly represented in inpatient care as compared to Whites, with the exception of private psychiatric hospitals.

So, clearly, the mental health needs of racial and ethnic populations are not being adequately addressed by our current mental health system.

Human Potential Losses

Chapter three of the Surgeon General's report involves a lifespan approach to mental health. We dealt with mental health problems in children, adolescents, adults, and older adults. We estimate that 20 percent of children and adolescents experience a mental disorder each year, yet only about one-third of those who need mental health services actually get them.

It is clear that mental disorders among children and adolescents are not restricted to any social class or racial heritage. Children most at-risk, however, are those who have physical and/or intellectual disabilities; who have a family history of mental and addictive disorders; who are in families that have experienced multigenerational poverty; and/or who have suffered
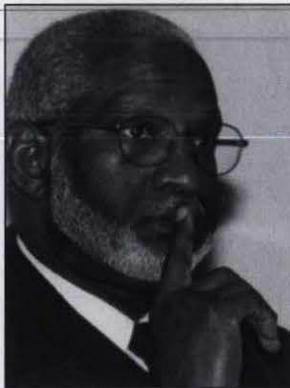
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> To remedy the problems of mental illnesses—including the extreme act of suicide—we must tear down barriers and develop new approaches to mental health.

caregiver separation, abuse, and neglect.

The report also points out that when children from these backgrounds do not receive the treatment they need for mental illnesses, they often end up in the juvenile justice system, and, subsequently, in the criminal justice system. This is particularly true if the children are from minority families. Minority children and adolescents, therefore, are much less likely than Whites to get the help they need and much more likely than Whites to be trapped in a system from which many never return. This represents not only a loss of freedom but also a loss of tremendous human potential.

Violent Acts of Despair

In the *Call to Action on Suicide Prevention* —released just a few months before our mental health report—we pointed out that more than 30,000 Americans were taking their own lives each year.

In fact, for every two people who die from homicide in America, three people die by suicide. Emergency rooms every year treat more than half a million people who have attempted suicide. These violent acts of despair and loss of hope plunge hundreds of thousands of families into grief and guilt, pain and remorse, because a loved one has "unexpectedly" committed suicide.

And again, some minority groups are disproportionately affected. Since 1980, for example, suicide has doubled in young Black males. Native Americans, with high incidences of alcoholism and despondency, die by suicide at an alarming rate. The *National Strategy for Suicide Prevention*, due out soon, will help to educate, motivate, and mobilize the American people around this important public health issue.

To remedy the problems of mental illnesses—including the extreme act of suicide—we must tear down barriers and develop new approaches to mental health.

One major barrier we continue to face is the stigma surrounding mental illness. From our perspective, stigma impacts on three levels.

First, stigma keeps an individual from seeking help or even admitting he or she has a problem. This starts early. In a discussion with teenagers in Portland, Oregon, we heard them talk about depressed friends who contemplated taking their lives. In such circumstances, these young people admitted they faced dilemmas: whether to take their friends seriously, whether to tell someone, and, if they decide to, whom to tell. To whom do they turn? Teachers? Parents? One young woman said, "Despite my questions, I finally decided that I would rather lose a friendship than lose a friend." So she started a program that involves young people reaching out to each other in suicide prevention.

Second, stigma impacts the family and the community. It helps shape the reaction of family members to symptoms of mental illness so that they are ashamed or fearful to admit that a relative has a problem and, as a result, they are reluctant to seek help. Stigma also helps shape the negative attitude around mental illness in communities, hindering people from getting the help they need. That is a major concern.

And third, stigma impacts policy. It may be that at this level stigma is most devastating, because it reaches past individuals, families, and communities to the people who make decisions in the halls of government—decisions about equity of treatment and parity of access. That is, in part, why it has been so difficult to get parity of access for mental health services. Stigma allows policy makers to feel comfortable discriminating when it comes to access for mental health services. This stigma involves ignorance of the fact that we so often can effectively treat and control mental illnesses.

In the Surgeon General's report, we assert that we know more about mental illness than we know about mental health. It is painful to admit that, but it is true.

Barriers to Success

A second barrier we face in bringing equity to the mental health arena is distrust of the system. Among African Americans, Native Americans, and, probably to a lesser extent some other minority groups, there is a distinct lack of confidence in the health system. They question whether they can get quality care for their mental health needs. Many of them doubt it so strongly that they stay away.

Cost is another barrier—a barrier made worse by our system of care and by the lack of parity of coverage for mental health services.

A fourth barrier is the lack of culturally competent providers—people who understand the culture and the language and who also understand mental health. That is an area in which we need to make real progress.

Finally, there is the "science barrier." How much really good research has been done to answer our questions? We take a lot of pride in the fact that our reports are based on good science, not personal opinion, not politics. The White House does not approve the reports; the administration does not even see them until we finish. Congress does not approve them; its members are not involved. We insist that the reports are based on the best available science.

Sometimes, however, that science is not easy to come by. We want to do more than we are able. We need more good science. We need more funding for research in mental health. We need more people doing research in mental health and different populations. We need a national strategy for dealing with stigma.

We need to improve the supply of mental health services in terms of the diversity of mental health service providers. But also we need to develop a comprehensive system of community mental health services —a system that creates partnerships between primary care providers and mental health specialists, so that people who are discharged from institutions are not lost but continue in locally-based care.

Parity and Promise

We need to deal with parity. Beginning this year, any health plan that provides coverage to federal employees— and there are almost three million of us, not including our families—must provide parity of access for mental health services. That is a major step forward. More than 30 states have passed parity laws. Some, of course, are less than desired, but we are making progress. If we focus on mental health, and especially on the needs of people who tend to be left out in our system, we will move toward equity and parity for all—a system that will balance health promotion, disease prevention, early detection, and universal access to care.

In the Surgeon General's report, we assert that we know more about mental illness than we know about mental health. It is painful to admit that, especially for a former director of the Centers for Disease Control and Prevention, but it is true. We know more about how to treat mental illnesses than we know about how to promote mental health or prevent mental illness.

Our challenge, then, is to do more science. We have to gain a better understanding of how to promote mental health and prevent mental illness; then we have to make the commitment to follow through - not just because of cost implications, but also to prevent so much unnecessary pain and suffering.

As challenging as that is, I believe we can do it. Former Secretary of Health, Education and Welfare John Gardner used to say, "Life is full of golden opportunities, carefully disguised as irresolvable problems."

I think we need to stop using the word stigma, which most consumers don't like, and talk about discrimination and prejudice, which is what stigma really is. Everybody understands what discrimination is. Everybody understands what prejudice is. Stigma has become mostly a mental health-specific word; even the media doesn't understand it very well.

SATCHER: The issue of language is not easy. I am not sure we all agree that stigma means discrimination in all cases, any more than we all agree with those people who feel we should stop using "mental illness" and start saying "brain disorders."

What is appropriate for us is to continually examine our language. We face the challenge of making sure people understand our language, as opposed to changing it. So we all have to struggle with what a word like stigma means. Does stigma really mean discrimination and prejudice? Or does it include something broader than that? I think the reason we haven't shifted from stigma to other terms is that, in fact, we are not sure the terms mean the same thing.

However that discussion comes out, the important point you make is that language is very important, and we must make every effort to make sure our listeners and our readers understand what we mean by the terms we use.

How can we reach those who have a profound distrust in our medical system?

SATCHER: People want access to trustworthy services in their communities; they want to believe that when they seek care, they will get care and not discrimination. So my generic answer is we have to involve communities more in all the programs, in all the research, and in all the services.

We have developed models for community involvement and responsibility in

32 sites; funded by the CDC, they make services more responsive and accessible. But not every community has them. So we developed "crisis response teams"—people from the CDC, from my office, from the National Institute of Mental Health—who go in to identify community leaders and help them create strategies for dealing with local health programs.

Still, these are not enough. We have to find a better way to reach communities. We have to involve local people in program decisions if we are going to create that aura of trust so vital to successful mental and physical health care.

How can we deal with the anti-mental health people who talk about plots between drug companies and psychiatrists to diagnose mental illness so they can sell more medications? How do we address such propaganda issues?

SATCHER: There are, unfortunately, a lot of people who are anti-psychiatry; they have strong feelings about the validity of the whole field of mental health research and treatment. I am glad they are in the minority. But I do not have a solution to the problems they create.

It is like people against immunizations. In that case, we decided simply to make sure that immunizations are safe and effective, to continue research to improve them, to continue to distribute data that show the overall benefits of immunization. We do not attack the nay-sayers; we present the positive image that immunizations are good for people.

Some people will never change their minds because of what we say, but we have to make sure that we continue to show people the efficacy of mental health services.

A compatriot of mine, an African-American

> A lot of people have strong doubts about the validity of the whole field of mental health research and treatment. I am glad they are in the minority. But I do not have a solution to the problems they create.

consumer of mental health services who unfortunately died this year in his mid-fifties, often said to me, "One of the most important things that we have to have is jobs. You have to help get us jobs. It's important that we have work."

His point about the link between work and mental health seems important to me, and reflects the need for mental health advocates to join with others in promoting a more holistic front to health. Do you envision such partnerships and if so, what partnerships do we need to mobilize the kinds of resources required to promote mental health?

SATCHER: You have defined one of the real struggles of public health today.

We have just released *Healthy People 2010*, the third in our series of decade-long looks at ways to promote the health of the American people. Good health, we have found, is not just about physical or mental health as isolated from other components of living. Health is about education and jobs and self-esteem.

For mental health, you need more than mental health services. You need things that promote community infrastructure, self-esteem, and family strength. Our attitude about that, of course, is that we are part of a team. And that team has made it a priority to strengthen families in this country in terms of jobs and welfare reform. Giving training, giving child care, improving transportation—all of those and many other things are part of this partnership.

So, you are right. When we talk about mental health services, we are not implying they exist in isolation. They are a part of a whole system meant to improve the lives of people and families.

Supplement Insights

The first panel discussion features authors of the report supplement.

Nelba R. Chavez, *Moderator*

Nelba Chavez, Ph.D., is Administrator of the Substance Abuse and Mental Health Services Administration. The first Latina to head a public health agency in the 200-year history of the U.S. Department of Health and Human Services, Dr. Chavez directs federal policy and advises the Secretary of Health and Human Services on substance abuse and mental health issues. Before her appointment, she served as director of Juvenile Probation Services in San Francisco. She headed Chavez and Associates, a behavioral health consulting and training firm. For 17 years, Dr. Chavez ran La Frontera Center in Tucson, Arizona, a community mental health center. Dr. Chavez' BA in sociology and psychology is from the University of Arizona in Tucson, her Master's of Social Work from UCLA, and her Ph.D. from the University of Denver.

T he first supplemental report to the *Surgeon General's Report on Mental Health* focuses on race, ethnicity, and culture. Many of us have been talking about issues related to the report for many, many years. We have lived with the problems and welcome an opportunity to address them in meaningful, intelligent, and hopeful dialogue. So we came together at the annual Rosalynn Carter Symposium on Mental Health Policy to look at what is happening in this area. It also is fitting that at the dawn of the millennium, we are finally seeking new ways to address cultural diversity, and that we are moving from a concept of assimilation toward integration, and from a practice of inequity toward parity.

As we began this report, we realized this was an unprecedented opportunity: We had a window of time to develop a report that would have tremendous impact on all Americans. We planned to push the envelope beyond the traditional medical model of disease and treatment to address culturally appropriate care. We planned to broaden our vision by adopting a holistic approach that spans the bio-medical and the behavioral sciences.

In short, we were going to look closely at all factors that contribute to good mental health. We planned to embrace the individual's environment, his or her culture and ethnicity, because that is part of who we are and we cannot separate ourselves from that. We also intended to build on cultural strengths that help sustain good mental health.

Following this agenda has not been easy. Our job has been complicated by the historical weight of inequality that sometimes limited how we viewed not just the research, but also the clinical practice.

Nevertheless, because we sought to unite the many disciplines that provide insight into disparities, we have been able to craft this report in a framework whose foundational tenet is that diversity and cultural richness define our nation, give us unusual strengths, make us unique, and pilot us toward our future.

Creating this report has challenged the experts involved to think outside the box, to identify ways to place mental illnesses and the promotion of mental health within a cultural context. Their discoveries, the scope of their analysis, the values they recovered and defined, determined how and what information would be incorporated into the report.

Michael English
Surgeon General's Report Coordinator

Michael English, J.D., is Director of the Division of Knowledge Development and Systems Change in the federal Center for Mental Health Services. He is also responsible for the Children's Services Grant Program and projects for assistance in transition from homelessness. In May 1998, Mr. English received the Department of Health and Human Services Secretary's Award for Distinguished Service for "visionary and dynamic leadership in managing the new knowledge development and application initiative to improve services for adults with serious mental illnesses and children with serious emotional disturbances." A graduate of Georgetown Law School, Mr. English has devoted more than 20 years as a litigator and an administrator in the area of mental health services.

The development of this supplemental report has been iterative and increasingly ambitious. As you know, reports by the Surgeon General reflect the state of the science with respect to their topics and the Surgeon General holds a high standard of what science should be addressed. In this case, after tremendous input, we spent the first stage trying to narrow the information to the most scientifically reliable.

And what happened?

We lost the richness. We lost the flavor. We had a firm foundation in the science—that is something we will retain. But this kind of research cannot just report the current state of the science. That would lose the sense of the history, the perspective, and the strengths that minority groups bring to the issue of mental health in America.

The second thing we learned was that most of the science has to do with conditions and prevalence of mental illnesses. Issues important to the Surgeon General—promotion and prevention, early intervention, giving people an opportunity to participate in their own health—were outside the confines of the most reliable science. To address these meaningful and interrelated issues of intervention and participation in ways that will move the Surgeon General's agenda forward, rather than reflecting solely on failures of the past, we have decided to address mental health factors like cultural identity, family influence, and ethnic involvement.

We asked, for example, what can a strong family do with respect to mental health, acculturation, coping mechanisms, help-seeking behaviors, resilience among children, effects of language, issues of service preference, and mistrust and accuracy of diagnosis, all issues having to do with the extent to which we can promote mental health in America, especially among people who bring a rich cultural heritage to their health perspective.

Our struggle now is to address these issues in a way that maintains the strength and reliability of the scientific basis of a Surgeon General's report, yet at the same time considers the absolutely critical issues around this important topic. This is not easy. But based on the work of the original chapter authors, I feel very hopeful this report will make a difference and that its contents will expand horizons beyond utilization and prevalence issues, even beyond access-to-services issues, as incredibly important as those are.

Spero Manson, Ph.D., is Professor and Head of the Division of American Indian and Alaska Native Programs, Department of Psychiatry, University of Colorado Health Sciences Center. He is also the Director of the National Center for American Indian and Alaska Native Mental Health Research.

The Native American Condition
Spero Manson
American Indians and Alaska Natives Section

What do we know about the nature and extent of emotional and psychological problems among Indian and Native people and the services made available to them to deal with those problems? From 1980 to 1995, more than 2,000 journal articles and book chapters were published on the mental health of Indian and Native people from birth to elderhood. Slightly more than a third of

Investigators inter-
viewed 150 youths
who had been booked
into a prison over a
ten-month period.
Nearly half met diag-
nosis for at least one
alcohol, drug, or
mental health disorder.

those, approximately 700 publications, spoke to some aspect of actual service.

What topics were emphasized? More than three quarters of those 700 articles spoke about the need for culturally sensitive assessment and care. They underscored the importance of family and community to the treatment process. They emphasized the limitations of the delivery system and the lack of local input into delivery structures and processes. And importantly, they under-scored the importance of traditional, cen-turies-old healing systems that often have operated alongside, rather than in coopera-tion with, modern medical practices—though this may be changing; we now see they are beginning to interface with medical systems emerging in Indian and Native communities.

Unfortunately, there is relatively little empirically based information or knowledge in these pre-1995 publications. Nearly 70 percent have no data, but are based on assertions and anecdotal evidence, and speak to the poverty of information avail-able—poorly designed studies and/or reviews of management information systems that are of questionable quality.

Over the past five years, however, we have seen dramatic growth in carefully con-trolled, diagnostically informed, community-based studies in mental health services in American Indian and Native communities.

What lessons have we learned?

The first important study after 1995 is referred to as "The Flower of Two Soils." It is a school-based study of the psychiatric status and psychological functioning of Northern Plains youth, grades three through six. This particular study employed state of the art diagnostic tools to canvas the young people's emotional and psychological status. The result? Nearly 30 percent of them quali-fied for a psychiatric disorder.

The vast majority of problems center

on substance abuse, but they are followed closely by disruptive, anxiety, and mood-related disorders. Nearly 13 percent of the youth met criteria for multiple disorders. But even more important, 39 percent of the youth diagnosed with psychiatric disorders reported only treatment for alcohol or drug problems, and this basically through school programs. Only one adolescent received care through a mental health specialist. Among the youth with psychiatric disorders who received no services, 57 percent were recognized as having a problem by a parent, teacher, or employment worker. This recog-nized but unmet need further evidences the lack of access and availability of care in Native American communities.

Another important study, conducted in a residential substance abuse treatment setting—we have a large number of these facilities for Native children and adolescents —examined the extent to which youth who manifested emotional and psychological problems were treated. Nearly 68 percent of the youth residents in this center screened positive for at least one serious psychiatric symptom, ranging from suicide attempts through major mood swings. Yet, despite recognition of serious symptoms of psy-chopathology, there was absolutely no rela-tionship between the likelihood of that individual receiving mental health care and such an observation.

The next study—conducted in a reservation jail—looked at both the preva-lence of emotional and psychological prob-lems, as well as the extent of services offered. Investigators interviewed 150 youths who had been booked into this facil-ity over a ten-month period. Nearly half met diagnosis for at least one alcohol, drug, or mental health disorder. Nearly 13 percent had two disorders and nine percent had three. The most common disorders were substance abuse dependence, conduct disor-

Despite advances in our understanding of Native American's mental health needs and treatment opportunities, much is still unknown.

der, and major depression. As we might expect, the rates of psychiatric problems among the detained youths were significantly greater than their counterparts in the community. But most importantly, 67 percent of the boys and nearly three quarters of the girls who had been booked into this facility and met criteria for a psychiatric disorder, had no history in the year before their admission of receiving or seeking any kind of treatment or care. Nor did they receive any mental health care during their retention.

The next study—and I was part of the team involved in it—concerned a longitudinal survey of more than 600 families physically affected by the 1989 Exxon Valdez oil spill in southern Alaska. We compared Native to non-Native residents within the villages, as well as their counterparts in non-affected villages. The extent of psychiatric morbidity as a consequence of the oil spill was significant. Nearly 20 percent of the residents post-spill met criteria for generalized anxiety disorders, 17 percent for depression, and 10 percent for post-traumatic stress disorder. The psychiatric consequences of the oil spill were particularly significant on the Native residents. A Native elder explained why: "Well," he said, "when grandparents, parents, and grandchildren go out to gather the mollusks or to hunt, we use this time to convey the importance of our place in the world around us. This is how we relearn who we are and our responsibilities. The oil spill has disrupted that and placed us at great jeopardy."

My final illustrative study comes from military combat. This study, completed in 1996 among Native Americans, replicated the National Vietnam Veterans Readjust-

ment Study of the mid- to late-1980s. Nearly 30 percent of the Native American Vietnam combat veterans suffered post-traumatic stress disorder. That is from one to three times greater than reported by their White, African American, or Hispanic American counterparts in the earlier study.

The prevalence of alcohol abuse and dependence was more than 70 percent, again, three to five times greater than their counterparts. Interestingly, we also saw considerable health seeking, including use of traditional healing resources. In fact, when we combine the use of biomedical and traditional healing resources, the overall rates of service use were equal, underscoring the importance of traditional healing resources in Native American communities. The Veterans Administration has subsequently recognized traditional healing's value and begun reimbursing for its use.

Despite these advances in our understanding of Native American mental health needs and treatment opportunities, much is still unknown. The literature is silent with respect to the mental health status and service needs of infants and the youngest children. And we know little about the adequacy of existing services for the most seriously disturbed of our youth. There are no data, none at all, regarding the burden of care or the mental health consequences for the families of these youth. We have little data about service outcomes.

And lastly, the systems of care for Native Americans are undergoing rapid change. We do not know the implications of managed care for the delivery of services and their financing. So we continue to be challenged to bring our knowledge abreast of Native American needs.

The African American Condition

Lonnie R. Snowden
African Americans Section

Lonnie R. Snowden, M.D., is Director of the University of California Center for Mental Health Services Research, an Affiliated Professor in the Department of Psychology at the University of California, Berkeley, and an Assistant Professor at the School of Social Welfare at the University of California at Berkeley.

African Americans are less likely than Whites to make use of care in a specialty mental health sector. That is a well-established fact. And they are less likely to see specialized treatment personnel for problems in mental health.

There are exceptions—in the public sector care, especially in large cities, African Americans are equally and sometimes overly represented—but in the nation as a whole, African Americans in outpatient specialty care are underrepresented. That covers both children and adults, although there are exceptions for children and youth as well.

African Americans are more likely to drop out of treatment once they have entered. That is another well-established finding. African Americans attend fewer sessions; they often come in for only one session, so their patterns of use tend not to be the most productive and effective mental health treatment. African Americans are over-represented in psychiatric inpatient care. And they are over-represented in the emergency room.

Viewing these patterns in the context of the general medical sector, we can add that African Americans are less likely than others to make use of routine health care.

But among those who go, African Americans are more likely than others, by an appreciable degree, to present a primary care provider with a mental health problem. This suggests that African Americans substitute primary physical-health care—or at least *rely on* primary care—for treatment even when mental health conditions are the problem.

Those facts are important in understanding and overcoming disparities in African Americans for treatment of mental illnesses. Consider, for example, the prevalent use of emergency room treatment by African Americans. This is generally attributed to problems in health insurance, but it reflects other conditions as well. One of them is that African Americans often lack a primary source of health care. As a matter of fact, in the absence of easy access to physicians and treatment, the ER sometimes becomes the usual—the primary—source of healthcare.

Again, the culprit for such conduct is often financial. But financing is not a complete answer. With respect to outpatient care, privately insured African Americans are among the least of African Americans to use mental health treatment. A climate of acceptance and trust is important.

Returning to financing brings us to several points about African American income distribution. On the one hand, there is a large and growing African American middle class. On the other, African Americans continue to be over-represented among the poor, including the working poor. Among people whose incomes lie below the poverty line, a disproportionate number are African Americans, especially African American children.

Children's Issues

Speaking of children, not only are they among the poorest segments of our population, they also represent a growing number of those in living with someone other than their biological parent(s). A recent *Time* magazine cover story on foster care, for example, points out that nearly 600,000 youngsters are in foster care today. Some 50 percent of them are African American. They are in the child welfare system, after

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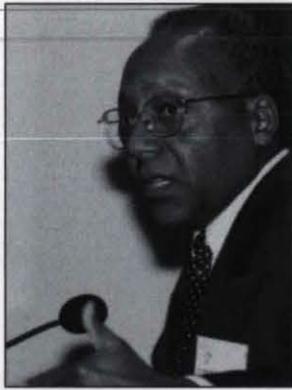
Strengthening the bond among therapist, practitioner, and patient will increase the likelihood that African Americans will initiate treatment more readily and adhere to the physician's advice more willingly, and the results will be more productive.

all, because their home life was unacceptable as a result of death, abuse, or neglect. Their levels of need are very high. And while care is provided, we do not know how much, whether it is appropriate, even whether it does any good.

African Americans also are over-represented among people who have few assets. African American assets—the houses, cars, businesses, etc., owned by African Americans—are a very tiny proportion of White assets per household. Much of this reflects African American's agricultural heritage; they never had much to pass on. But it also predestines a certain social precariousness, a lack of roots: when problems arise, African Americans are quicker to move.

And the final point in this downward spiral, of course, is homelessness. African Americans are three-and-a-half times more likely to be homeless than is any other racial group. And the homeless—as is also well documented—have high levels of problems in mental health and substance abuse. Programs that address the problems of the homeless, therefore, promise a beneficial impact with African Americans.

The Scourge of Poverty

Poverty affects other aspects of African American life and access to health care of all kinds. African Americans continue to be over-represented among the uninsured. But when it comes to receiving mental health care, the differential rates of utilization between African Americans and Whites vary according to the source of insurance. For African Americans or Whites on Medicaid, there is virtually no disparity in use. However, among all the insured, there are substantial differences in use of medical treatments; African Americans adults and children are less likely to seek outpatient mental health treatment. We tend to think that middle class status

(and income) is sort of a leveler, but in this instance, it is not. Left to their own, apparently, African Americans seek health care in disproportionally low numbers.

Over the years, some physicians who have specialized in African American clientele have built up a body of wisdom about what will prevent these dropout problems. There is evidence, for example, that programs specializing in African Americans' needs do not demonstrate the problems of access and immunization that those non-African American-oriented programs do.

Another issue is the distribution of providers. African Americans live disproportionally in the South and in central cities, where the number of health providers is somewhat lower.

In the current managed-care environment, we need to make special efforts to ensure that those providers and programs continue to serve African Americans. It is a situation where everyone ought to win, not only clients from African American backgrounds, but also managed behavioral health care organizations and society at large.

We also need, as this summary emphasizes, to promote effective therapeutic alliances. It makes intuitive sense that strengthening the bond among therapist, practitioner, and patient—especially in the case of mental health—will increase the likelihood that African Americans will initiate treatment more readily and adhere to the physician's advice more willingly, and the results will be more productive. Such a pathway for understanding might overcome the mistrust minorities feel with the medical system as it now stands. Care that specializes in African American needs and effective therapeutic alliances could go a long way toward overcoming barriers and disparities and bringing equitable mental health care to the African American population.

The Hispanic American Condition

Steven R. López
Hispanic Americans Section

Steven R. López, Ph.D., is a member of the faculty in the Department of Psychology at the University of California, Los Angeles.

Currently in the United States, almost 12 percent of the population is Latino. According to the Census projections, in 2050, Latinos will comprise 24.5 percent, or almost a quarter, of the nation. And all minorities, by 2050, will make up almost 50 percent of our people.

So the numbers alone indicate we must address the mental health concerns of these different communities; in this case, Latinos. But it is not just their size, it is also Latinos' geographic spread. Most picture Latinos in California, Texas, New York, and Florida. But the greatest growth of Latinos throughout the United States is largely in the South—Arkansas, North Carolina, Georgia, Tennessee, and in other unsuspected places: Nevada and Nebraska, for example. No longer can we consider Latinos regional phenomena in the Southwest, Southeast, or Northeast.

Although their presence is national, efforts to address Latinos' mental health needs in places outside their traditional residences may be even harder because those areas have little history of working with Latino communities. Cultural and linguistic barriers are bound to be great.

In working on the supplemental report for the Surgeon General, I reviewed nine community surveys of the mental health problems of Latino children and adolescents. Most of them revealed that—across different sets of communities, across different indices—Latinos reported the greatest mental health needs. One example was from a national study carried out by the Centers for Disease Control and Prevention: More than 16,000 high school students, ninth through twelfth grade, were surveyed.

Hispanics reported more suicidal attempts than any other ethnic groups. This probably reflects a cry for help, a distress signal from Latino adolescents in many different communities.

A second finding from my review of the research is that Latinos under-use mental health services. The best available data comes from Fresno County, California. For this study, more than 3,000 Hispanics of Mexican origin were interviewed; a little over 500 of them met criteria for a diagnosable disorder. Yet during the preceding 12 months, only 8.8 percent of them had used mental health specialty services. The good news was that a much higher percentage of Latinos did seek primary health care. So that alerts us to an opportunity to link mental and physical health care for more effective delivery of mental health services to Latino populations.

What about treatment? We need much more data, but my sense is that we have methods for intervention that can work with Latinos. A wonderful example comes from Bill McFarland in Portland, Maine, who uses multifamily group interventions in contrast to single-family intervention. He brings together multiple families—consumers or patients and their family members—and intervenes with a psycho-educational approach that includes problem solving. He has found that, after two years, those in multifamily treatment plans are less likely to relapse than folks in the single-family treatment. This study was based on six New York City public hospitals using the clinicians from those facilities.

Although this approach was not validated with Latinos, it may be valuable for Latinos because, one, it is family oriented,

and, two, it takes into account the families' social worlds. McFarland argues that having multiple families come together enhances the social networks within the families. While there is no systematic data to document that viewpoint, anecdotal evidence and clinical observations lend it support. I think that to make this a viable intervention for Latinos it is just a matter of making a few minor adjustments. It has great potential.

Yet even with positive treatments available, certain barriers—many of them the same barriers that affect Native Americans and African Americans—certainly keep Hispanic Americans from mental health services. A major one is insurance; another involves the juvenile and criminal justice systems, and the problems that result from incarcerating people who need mental

health services.

Although much more research is needed we must remind ourselves that a failure to act given limited data results in human suffering. Human lives are at stake. Although limited, we do have a knowledge base. It is a matter of bringing it forth in a systematic fashion to have an impact on the breadth and quality of care for minorities.

And this will happen when we bring the family together. Not only the family in terms of parents and siblings, but also the family of service providers, the family of policy makers, the family of federal agency representatives, and the family of consumers. With all our coordinated efforts, we will be able to remedy the disparities in mental health services that trouble Latinos.

The Asian American Condition
Stanley Sue
Asian Americans Section

Stanley Sue, Ph.D., is Director of the Asian American Studies Program, Professor of Psychology, and Director of the National Research Center on Asian American Mental Health at the University of California, Davis.

Like Hispanics, Asian Americans are a fast growing ethnic minority group. Although they number only about 11 million in the United States—about four percent of the population—their growth has been tremendous.

Asian Americans comprise 30 to 40 distinct groups, the largest among them being Chinese, Filipinos, Japanese, Koreans, and Vietnamese. Another important group is Pacific Islanders—Hawaiians, Samoans, Guamanians, and others. Asian Americans' diversity does not end with their country of origin. Even individuals within a subgroup like the Chinese can speak many different languages and dialects. Asian Americans also differ in terms of their acculturation level, with some being recent immigrants and others being seventh

generation Americans.

There is a pervasive stereotype that Asian Americans are highly successful. It is true that the median family income of Asian Americans is higher than the national average; educational attainments also are higher. But these statistics should be tempered with some other facts. For example, in Asian American families, there are usually more earners, so overall they produce a higher household income. Yes, educational levels are high, but there is also a very high percentage of Asian Americans who have no education whatsoever, so we have kind of a bimodal distribution for education.

The stereotype of success unfortunately carries over into the mental health arena. But are Asian Americans successful in terms of mental health adjustment? There is no

Many Asian Americans carry a great deal of shame and stigma over mental health—it conflicts with the concept of "face."

evidence that Asian Americans are less likely to experience mental disorders than other groups, but getting a good picture of Asian Americans' mental health status is difficult.

In the area of depression, for example, studies have found Asian American rates to be higher sometimes than other Americans, sometimes about the same. Anxiety studies present both high and very low rates. Why does such variance in findings exist? I believe the discrepancies are attributable to three factors:

One, Asian Americans are a small population, so sampling has been terribly difficult. For example, one study had to sample 20,000 households to get 1,700 respondents. Given the sampling problems, different studies have used different methods to sample. This increases the possibility that the studies are not comparable and the samples may not be representative of the population of Asian Americans.

Two, Asian American diversity can produce different findings. For example, when we try to examine the mental health of Chinese Americans, we are dealing with a very heterogeneous group in the United States—more so, in fact, than Chinese in China, because those in the United States differ in acculturation levels, languages, countries of origin, geographical backgrounds, and other factors. Such diversity often makes it very difficult to compare studies because the samples from studies may differ.

Three, the population is ever changing in its characteristics. Because of immigration, we see dramatic shifts. For example, two decades ago, when thousands of Southeast Asian refugees came to the United States, their mental health probably altered the findings for the entire group of Asian Americans. Southeast Asian refugees were among the most disturbed populations ever found in the United States, a result of trau-

mas they experienced in the evacuation from their homelands and the dangers of reaching safety. High rates of post-traumatic stress disorder and depression were part of this rapid immigration. Today, with fewer refugees entering this country, the mental health of Asian Americans would probably be different that what it was a couple of decades ago.

Thus, it is difficult for us to specify what the precise rates of mental disturbance are. However, we believe from the available evidence that Asian American rates of mental illness are consistent with other populations.

Shame and Stigma and "Face"

Unlike the varying prevalence rates of mental illness found in various studies of Asian Americans, the findings on mental health utilization are consistent: Few Asian Americans are using mental health services. There is under-utilization regardless of age; among children as well as adults; men as well as women; in locations of a high Asian American population density as well as low population densities. For example, in California and in Iowa, there is under-utilization.

Researchers believe this situation occurs for a number of reasons, including shame and stigma. Many Asian Americans carry a great deal of shame and stigma over mental illnesses—it conflicts with the concept of "face." "Losing face"—something akin to bringing great shame not only on the individual, but also on his or her family —is something to be avoided.

Years ago, I worked at a Veterans Administration hospital in San Francisco and also at a Chinese community center, Cameron House. While I was at the VA hospital, a Chinese woman came in with her husband. Very disturbed, he spoke only Cantonese, and I understood enough to

> We have to monitor our mental health systems. We have to examine the conditions in mental institutions, treatment facilities, and we have to promote more cultural responsiveness.

know that he thought the communists were trying to kill him and his wife was trying to poison him. But my Cantonese was very limited, so I said to the wife, "Why don't you bring him over to the Cameron House where they have a psychiatrist and psychologist who can speak the language?"

The wife says, "I feel terrible, but my kids play at Cameron House." In addition to offering mental health services, Cameron House is a community center. She said, "I can't bring him there because everyone would know he's crazy."

This woman was withholding service, relevant service, from someone she loved, because of her overwhelming feelings of shame and stigma: her fear of losing face.

Ancient Concepts

Another reason for under-utilization is that many Asian Americans have different concepts of mental health and mental disturbance. Many Asian Americans believe mental illness is the result of somatic or body factors. In seeking treatment, therefore, they often turn to the services of an herbalist, acupuncturist, and so on, rather than to a psychotherapist for talk therapies.

Furthermore, many Asian Americans believe that will power is a means of enhancing mental health; if you have mental health problems, you should exercise will power. This is an individual self-cure strategy. Why, then, should one turn to anyone else for treatment?

Furthermore, many Asians believe mental health is enhanced by avoiding morbid thinking: Do not think bad thoughts. Yet, if you go to the psychotherapist, you have to bring up bad thoughts. You have to talk through bad things. Many Asians walk out of therapy thinking, "How is this helping me, to talk about these bad things?"

Finally, our mental health system has not adequately responded to individuals, especially those from small ethnic populations.

Many years ago in Chicago, the Cook County Public Guardian, Patrick T. Murphy, filed a $5 million lawsuit against the Illinois Director of Mental Health, primarily charging that the Department had kept a Chinese immigrant in custody for 27 years mainly because the man could not speak English. The federal court suit charged that the Department of Mental Health had neglected to treat the patient—then in his fifties—for any mental disorders. Doctors conceded they could not give him a mental exam because he spoke little English, but they gave him a psychotic diagnosis anyway. The suit indicated that a doctor who spoke no Chinese said that David answered questions in an incoherent and unintelligible manner. David was quiet and caused little trouble, but he was placed in restraints sometimes because he would wander to a nearby ward that housed the only other Chinese-speaking patient (*see Sue and Morishima, 1982*).

Recently, I asked a group of administrators in Asian American mental health services if this was a unique example of inappropriate service. They said, "No," and agreed that this still occurs in many parts of the country, although the problem is probably not as egregious as in the example.

Even today, we have to monitor our mental health systems. We have to examine the conditions in mental institutions, treatment facilities, and we have to promote more cultural responsiveness.

Cultural Competency

We have to study cultural competency. What is meant by cultural competency? Can we measure it? Traditional measures of cultural competency have asked, "Are you sensitive to one's culture? Do you know much about one's culture?" These are

> We should require agencies to make public their policies of cultural diversity. There is increasing recognition of the importance of diversity: ethnicity, gender, sexual orientation, and religion.

not good measures. We must define cultural competency and develop measures to tell us who is culturally competent. We also must ask questions such as whether it is possible to train people to be culturally competent.

We should require agencies to make public their policies of cultural diversity. There is increasing recognition of the importance of diversity: ethnicity, gender, sexual orientation, and religion. We have to decide what are we going to do with it and how are we going to handle diversity in order to affect better mental health treatment outcomes.

We need to teach researchers to examine the efficacy of services provided to different kinds of populations and to use an array of research methodologies such as qualitative/quantitative methods, experimental methods, and so on.

We also need to educate our ethnic communities. For example, when speaking

in the community, I emphasize certain points. I try to convey there is nothing to be ashamed of if you have mental health problems. I tell my audience that treating mental health problems is as important as treating a physical problem. I insist, "If you have mental health problems, you should seek help right away." And I make sure my audience understands that the things one divulges to therapists will be kept confidential within the limits of the law.

These are messages I try to convey to various Asian American communities to reduce shame and stigma and to educate the public concerning mental health practices. In turn, ethnic communities should play a strong role in helping shape the nature of services and the ways that, together, we can improve the mental health of all of our citizens.

Sue, S., & Morishima, J.K. (1982). The mental health of Asian Americans. San Francisco: Jossey-Bass.

Q/A
With The Supplement Authors

In the supplemental report, do you address risk factors and protective factors that are within our culture and our ethnicity?

SPERO MANSON: On the question of risk and protective factors: Early on we began to consider the issue of spirituality, a notion extremely important among a number of subpopulations, Native Americans being a significant example. We wanted to study spirituality both in terms of mediating risk and enhancing mental health. Only recently, but importantly, we begin to see some empirical evidence on the effect of spirituality, but it is documented largely with respect to physical health disorders, less—though it is growing more common now—with respect to emotional/psychologi-

cal problems. Examining not only risk, but also protective factors in this context, may help us understand the balance between illness and health in these populations.

As chief resident at Atlanta's Grady Memorial Hospital on Psychiatry, I work in emergency receiving facilities. We have a fairly large Hispanic American population and I have been concerned by their under-utilization of services, specifically in the emergency mental health setting. Are there cultural correlates to that under-utilization of services?

STEVEN LOPEZ: Factors that contribute to under-use of services include ethnicity and immigration, as well as language. Another is the tradition of the facility to

treat and consider the concerns of that community. Are community members involved with the facility in meaningful ways? These are areas I would address to enhance service and reduce the barriers.

NELBA CHAVEZ: Basically, when people—especially people of color—tend to under-utilize services, it is because using such services are not within the family or the culture norms. A lot has to do with how the service system is set up and how responsive it is to the differences of individuals coming through the door.

You have discussed issues that contribute to disparities in mental health among minorities. But you have not mentioned differences in treatment response. It is now obvious that there are racial/ethnic differences in response to drug treatment. I imagine there would be racial/ethnic differences in other types of treatment as well. What is known on this subject?

LONNIE SNOWDEN: It is an extremely important area, but researchers have only begun to systematically document differences in treatment response, especially as they relate to cultural diversity. That is the next frontier.

PANEL MEMBER (Unidentified): Several years ago, I was on a clinical psychology task force to define empirically validated treatments. We looked at many, many studies, primarily cognitive behavioral, and were rigorous in accepting their validity. I checked to see if any included ethnic populations. Not a single one. We do not have good, rigorous studies of treatment outcomes for ethnics. They are coming out now; most on treatment outcomes are not as rigorous as we would like. We need a lot more of them.

SPERO MANSON: From my point of view, where the rubber hits the road is the extent to which our delivery systems are capable of diffusing and delivering technolo-

gies. In Native American communities, we have enormous turn over, particularly at the professional levels. So if these technologies require a high level of expertise and training, then they are unlikely to be adopted. Instead, we are looking to technologies that use paraprofessionals and ancillary health professionals, and we try to incorporate families and family advocates, which gives us a greater prospect of long term continuity.

In Philadelphia, we're trying to close a hospital that provides a high level of inpatient services for African Americans. Meanwhile, we are talking about cultural confidence. And, to me, that is not the point. The point is funding. We have heard that people need jobs, people need housing, and people need to be integrated into society. To do these things, we needs funds— there needs to be funding for the hospital we have to close, if we are going to offer minorities the services and treatments they deserve.

PANEL MEMBER (Unidentified): The report deals with funding in a limited way in a section we call "future directions" — practices that offer great promise. I think a number of areas of funding are promising. But it is certain that issues of parity—insurance coverage, reduction of cultural barriers— those are areas that are going to require more funding.

NELBA CHAVEZ: Financing mental health services means holding ourselves responsible, first of all, accountable for every dollar spent under our direction, every decision that impacts on our funds.

But it also is part of our responsibility to hold our elected officials accountable, to ensure that every door is an open door when people are in need of mental health services, regardless of their race, ethnicity, and/or diagnosis. Also, we are responsible for holding them accountable for improving the quality of mental health for all our peo-

> There is over-representation among specifically vulnerable populations that do not traditionally get served, and the jail and prison populations are highest among those groups.

ple, because we know that while there have been many, many advances in mental health services in the past 40 years, we have not done very well when it comes to systems of care in minority communities.

We all know ethnics are not being adequately served by the system. Among African Americans, many are not being treated. They are being imprisoned. The only way we have found to address the problem—which is, in effect, a funding problem—is to bring litigation claiming discrimination.

Have any of you ever addressed this issue in terms of the court proceedings. If not, why are we not asking the courts to explain why these people are not being served? Why are we not seeking redress under laws that protect minorities from discrimination?

MIKE ENGLISH: We know there is over-representation among specifically vulnerable populations that don't traditionally get served, and that the jail and prison populations are highest among those groups. So, there is a solid basis for asserting the service needs of those individuals. Current legislative activity is giving us an opportunity to move ahead in mental health services to criminal justice populations, both diversion from unnecessary incarceration and provision for the thousands of ex-offenders who come out every day in need of services.

There are two million people locked up in the country. Many, if not a majority, are people of color who suffer mental health and substance abuse problems. Large numbers of them would not be in jail if we had adequate community services. Large numbers of youth are cut out of community mental health services because they do not have the right diagnosis. They end up in justice systems even though studies of inmate populations show that between 35 and 70 per-

cent have mental disorders. I hope the report opens a dialogue about our systems' failure in this area.

Also, is it not important to talk candidly about the impact of racism on the mental health of people of color? Does racism have a place in the supplemental report?

LONNIE SNOWDEN: In my part of the report, I mention the importance of jails and prisons in understanding the African American mental health scene. A decision to exclude people in jails and prisons changes estimates of African American mental health fairly dramatically. It is vital to include people of color who are incarcerated in mental health discussions.

On a policy front, I am mildly optimistic. In California and perhaps elsewhere, I sense more willingness to recognize and talk about the effect that racism has on incarceration rates of people of color, as well as on the mental health needs of prison populations.

On the question of racism, research documenting race as a mental risk factor is being done now. I mention it in my report.

PANEL MEMBER (Unidentified): Back in the early 1970s, a book, *Racism and Mental Health*, argued the correlation of the two terms and discussed the paucity of services being offered to people of color. Then in the 1980s, social research was de-emphasized, funding for research became hard to get, so it became difficult to study racism. Now a number of people are trying to measure racism and how it differs among different groups, but the topic remains politically sensitive. Nevertheless, we need to investigate racism and look at it as more than a stress factor, but as a sort of cultural pattern, almost a value pattern, to which we need to stay attuned.
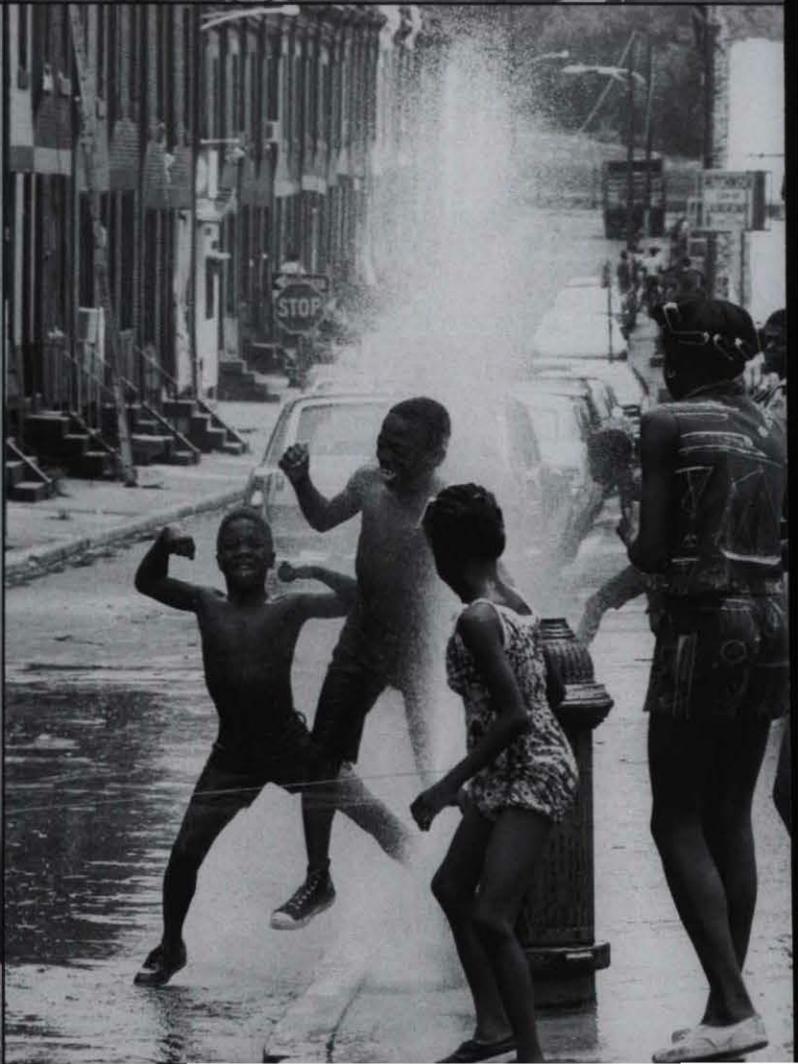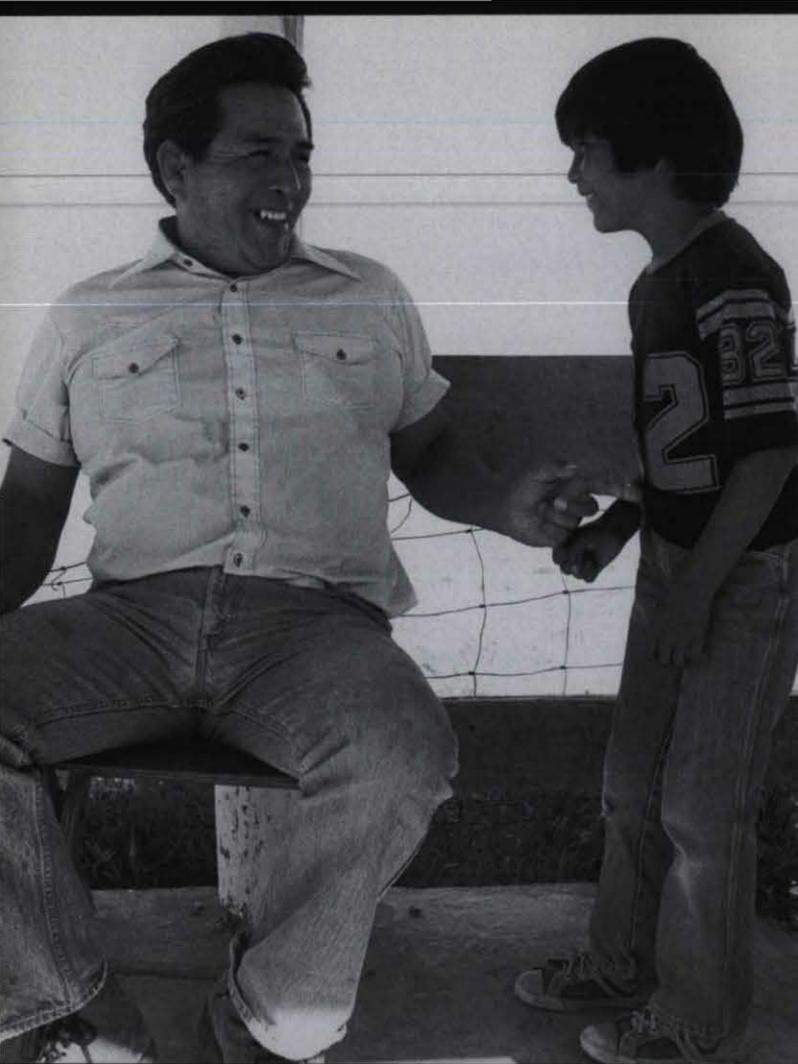
A Heritage of Indifference

We must break down the walls of stigma, the walls of silence, the walls of neglect.

Alvin F. Poussaint, M.D.
Professor of Psychiatry, Harvard Medical School

Alvin F. Poussaint, M.D., is Director of the Media Center of the Judge Baker Children's Center in Boston. Professor of Psychiatry and Faculty Associate Dean for Student Affairs at Harvard Medical School, he is author of several books, including *Why Blacks Kill Blacks,* and dozens of articles. In 1997, he received a New England Emmy award for outstanding children's special for "Willoughby's Wonders." He is active in consulting to the media on a wide range of social issues. Born in East Harlem, he attended Columbia University and received his M.D. from Cornell. He served with the Medical Committee for Human Rights in Mississippi and with Tufts University Medical School. In 1969, he joined Harvard University. He is a member of many professional organizations and has received numerous awards and many honorary degrees.

In the late 1960s, one of my main responsibilities working out of Jackson, Mississippi, was to desegregate the hospitals. Only 35 years ago, we began to get rid of segregated hospitals. I never understood why that was not higher on the civil rights agenda. Black people were dying unnecessarily because of segregated medical practices. Black people were turned away from White hospitals, no matter what their condition. If they went into a segregated hospital, it was obvious from just looking at the rooms and the equipment that they got the lousy part of everything. They had to trade their dignity to get medical care, then they also had to worry if the doctors would treat them or whether the doctors were bigoted and would let them die.

I mention this because it is recent in our history. And obviously it has a lot to do with the way Blacks will access service, their level of distrust. The Tuskegee Study, with its callous disregard for human life as it studied syphilis among Black men, is one example from many, many other studies.

So it runs deep, this fear and distrust of physicians, very deep. Even today, I hear Black patients say, "I'm not going to that hospital, they're gonna do research on me."

We desegregated a hospital in Mississippi and the "Colored" and "White" signs came down. About five months later, we went back to the hospital, the signs were down, but all the Black people were still sitting in the colored section and all the White people were sitting in the white section. We went to the Black side to someone we knew and said, "You don't have to sit on the colored side anymore. You can sit anywhere you want." He looked at me as if I was not too swift. He said, "You see the guard over there? Do you think his attitudes have changed since you took down the signs?" Then he said, "Do you think the attitudes of the nurses and doctors have changed?" He said, "If they don't like us sitting on the White side, we may not get any kind of care. They may let us die to get even."

You may say, "Doctors wouldn't do that." But if you have not been there, you cannot understand the feelings that Blacks have, the experiences they remember, that have created such negatives attitudes toward "White establishment" medicine and, yes, even toward psychiatry.

I worked in a low-income housing development with a medical outreach program. If nurses found people in the community with emotional problems, they would tell me. Then I would visit the home of their patient.

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> The Black community has suppressed discussion of suicide because of the shame and the guilt and the stigma attached to it.

A nurse one night told me about a Black woman who was terribly depressed. We went back to the home. She knocked and the woman answered. The nurse said, "I have brought Dr. Poussaint to see you." The woman said, "Is he that doc ... that psychiatrist?" The nurse said, "Yes." The woman was adamant: "He's not coming in here."

She was afraid of me. In that community and in communities all over America, Black people knew mental health, in some way, had things in common with the criminal justice system. They knew there were two officials who could lock you up against your will. One was a cop, the other a psychiatrist. Black people's experience with psychiatry was being committed to mental hospitals, in the North and in the South.

They did not get much outpatient therapy. They got committed. So that fear of what psychiatrists may do hammered another step in the ladder of distrust Blacks must climb before they can access physical or mental health services.

Brothers and Sisters

Psychologically, if you know something is happening "over there," even if it is not happening to you directly, you are affected by it. So all Black people—all members of any oppressed group — are affected by the oppression of one particular individual.

Racial profiling affects me, makes me nervous when I drive. I cannot get away from my feelings. That is a reality.

I know, you see, that because of racial profiling, innocent men—well educated, professional men—have been stopped, then something has happened—some confusion; police go for a weapon—and suddenly, they are shot and killed. It is a real psychological threat to me, to thousands of Black men. And it adds another layer of stress, aggravation, and fear that plays into whatever the

personal mental illness problem is for a Black male.

Walls of Silence

In the Black community, there is a wall of silence around mental health issues, particularly around suicide. Black people today — educated Black folks, professionals—will say to you, "We did not know Black people commit suicide." Others will say, "Suicide is a White thing."

The Black community has suppressed discussion of suicide because of the shame and the guilt and the stigma attached to it. This occurs among Whites, too, but it is particularly strong in the Black community.

One reason has to do with Blacks' faith. The majority of Blacks are Christians, and within the Christian church historically, suicide is a mortal sin. If you commit suicide, you don't go to heaven. Black culture —the gospel message, religious songs, and so on—frequently speak of the afterlife: things are tough now, you have to bear up, hang on, but there's something for you in the Promised Land. Because the vast majority of the Black population looked to the afterlife for salvation and redemption from the pains and trials of their life of discrimination and hardship, a suicide victim's being denied heaven was really critical.

That outlook toward suicide has other repercussions that make it important, in discussing the mental health of African Americans, to broaden the definition of suicide to include self-destructive behaviors that also lead to early death: substance abuse, alcoholism, high-risk behavior, confrontive and threatening acts; all these and others reflect the same dynamics that undergird suicide.

Hopelessness, isolation, lack of self-worth, feelings of failure—ingredients that provide the underpinnings for suicide also are the basis for much self-destructive

behavior, including homicide. Suicide is as violent an act as homicide. Yet violence prevention programs in many parts of the country offer conflict resolution, anger management, and other ways to counteract violence while suicide is not included in the discussions.

That makes no sense. Suicide is violence. And since we have more young people dying of suicide than homicide, it should be part of every violence prevention program. But we put suicide in the mental health category and homicide in another category that has to do with crime. In fact, the overlap means we should be thinking of most self-destructive behaviors in a mental health context. If we did so, we would have more opportunity for prevention; we would see young people as needing help rather than as being bad.

In the case of an attempted suicide, we look at the individual as needing help. In the case of an attempted robbery, however, we see the individual as evil. And seeing the person in that light means we, you and I, are not as likely to recognize and treat elements of depression, anger, and so on.

We need to push the boundaries of the concept of suicide to include other forms of self-destructive behavior. What about "slow suicide" or "slow-motion suicide"?

Asking to Die

My brother became a heroin addict when he was a teenager. That began his spiral downward. He would shoot up and I would pick him up off the floor. When I was going to help him, I would think— every single time—that when I got to him, he was going to be dead.

But he never was.

I would ask him if he was trying to kill himself. And he would say, "No, I was not." But a lot of the kids in the East Harlem neighborhood where we lived were dying of overdoses. I used to wonder how many of those overdoses were intentional: when were they committing suicide, when was it an accident? Or were many, in one way or another, suicide?

I began to think about other behaviors: accidents like driving a car off the cliff. Frequently, families call that an accident, because suicide has a stigma. They want to deny the implications of suicide. Even the media goes along. But what if we started thinking of these acts as suicides?

The terrible tragedy of Julius Irvin's son driving his a car off a hill into the lake and dying; the newspapers called it an accident. But was it? My brother ... Julius Irvin's son: are they unrecorded suicides? Are their deaths the kind that fuzzy the statistics of African American deaths and make it so hard to discover the mental health of a people?

My brother spiraled down in the typical fashion—in the hospital, off drugs, out of the hospital, back on drugs, into the hospital, petty theft, into jail, out of jail, can't get a job because he's been in jail, more drugs. He finally died of acute meningitis at age 42. He was two years older than me. Acute meningitis—the disease most worrisome back then before AIDS—he probably got from a contaminated drug needle. Now you get AIDS from contaminated needles. And you get the same lethal result.

Self-destructive behavior ... substance abuse, alcohol abuse, driving recklessly, pushing at the edges of life until you have no life at all.

Undercover Suicides

Marvin Wolfgang of the University of Pennsylvania, back in the late 1950s, described "victim-precipitated homicide." He did not label it as suicide, but he could have. One example is "suicide by cop,"

which has been documented. I don't like the term. It makes me nervous because it could be misused. But there is such a thing where people go after the police because they want the police to shoot them, to kill them, because they do not want to kill themselves. That is exactly what they want. There are many recorded examples.

A young Black man, emotionally troubled and depressed, went in the street with a gun. People called the police. The police came. The police, to their credit, recognized the man was mentally disturbed. The man kept telling the police to shoot him. The police refused to respond. Then he started walking toward the police with his gun pointed directly at them. The police opened fire and killed him.

When they examined the gun, they found it wasn't loaded.

That mentally ill young man on the streets of Miami forced the police to shoot him because he could not face for himself, or for his family, the stigma, the shame, of suicide—but was his act not, nonetheless, a clear case of suicide?

In the suicide note another young Black male left his mother, he said, "Ma, please don't tell anybody I shot myself because I don't want them to think I was crazy. Tell them that someone else shot me." Even when killing himself, he was trying to protect his family from shame.

Blacks Behind Bars

Between 1980 and 1998, the suicide rate for young Black males doubled, according to the Centers for Disease Control and Prevention. But we have no idea who these Black men are—rich, poor; businessmen, ex-prisoners; middle-class, poverty victims. There is no demographic information collected on them.

One million Black men are in jail, one in four are involved in some way in the criminal justice system. Are these the men who have made the suicide rate soar?

An article in the *New York Times* attributed the rise in suicides, at least partially, to Black's difficulty in adjusting to their new affluence. That logic seems bizarre to me —"Give me a job and I'll kill myself." It seems the same sort of reasoning segregationists used to justify separation of the races: "They can't handle freedom."

I do not like that argument, do not believe it, but I cannot prove it is wrong. Because we do not have the demographics to know, with any certainty, who these hopeless, despairing young Black males are who are killing themselves at shocking rates. But maybe the gangsta rappers in their music—glorifying violence, sanctifying hopelessness, embodying fatalism—give us more of a hint than *The New York Times*: are they not singing to us the human stories of these suicide statistics? Are they not asking, "Why be hopeful, why be peaceful, why be optimistic when you're not going to live to be very old anyway?"

If your own life is devalued, would you not tend to devalue the lives of others?

Beyond Excuses

The stigma of mental illness runs deeper than suicide in the Black community. A lot of Black people do not believe depression is a mental illness. Sure, we invented blues music. It is part of the Black cultural experience; people have the blues. But "the blues" is not a mental disorder.

Others afflicted with mental illness may see it in a religious context—somehow he or she is not religious enough, or is possessed by demons. Have faith, Sister; only believe, Brother, and you will be well.

If we are going to get help for Black men and Black women, we must change their ways of thinking about suicide, about depression, about personal weakness, about

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religious convictions—issues that overlap with the White community, but are more prominent among Blacks. We have to work to get families to talk about mental illness more openly. We have to get ministers to speak to it. We must make it clear that mental illness can be a physical illness - a chemical imbalance—and they need not feel stigmatized; it is a physical illness of the mind they can deal with. And if we do—as I have seen around the country—the floodgates will open and so many, many stories will pour out.

Opportunity and Outreach

There is an opportunity to reach out to the Black community. It may take more training in cross-cultural issues; it may take more sensitivity to issues of distrust and skepticism by Blacks. And it may take some intentionality to shatter stereotypes about who Blacks are.

One of the stereotypes about Blacks is that they are happy-go-lucky, everything rolls off their backs. If you are thinking that, you are not going to be sensitive to symptoms of depression. Those who are providing services have to look at themselves, examining how they perceive and communicate with clients from different ethnic backgrounds.

An example: When a patient starts telling a psychiatrist his or her problems, and the psychiatrist responds with, "Uh-huh. Uh-huh. Uh-huh. Yeah. Tell me more about that ..."—that doesn't work with a lot of Black folk. They emerge from a session like that feeling very negative. They interpret the psychiatrist's behavior as coldness,

not liking them, sending them a message not to come back.

So reaching the Black community goes beyond cultural competence to creating an atmosphere of mutual trust. Of making clients feel welcome in clinics. Of making them feel comfortable and accepted. And in that environment, efforts to bridge barriers and offer help can, in fact, help.

Open Doors, Open Ears

Recently, a Black talk show host suddenly revealed that 20 years ago he almost committed suicide. What saved him, he said, were his wife and his children. He locked himself in a room and he stayed there for two days, struggling to decide how to kill himself and when to do it. Finally, he said, his frantic family practically broke down the door; they came in, terrified, "What the heck is wrong with you?"

They insisted that he tell them what was wrong. And when he began to talk, they listened. They did not tell him to "snap out of it," they did not tell him he was stupid for feeling that way; they listened. And as he talked, he said, the desire to commit suicide kept dissipating and disappearing. There in that room, surrounded by his close family, he stopped feeling he wanted to die.

It is a lesson for us. We must find ways to break down the walls of stigma, the walls of silence, the walls of shame, the walls of neglect and indifference that surround and trap African Americans. And when we do that, we will make a difference in millions of lives.

Culturally Competent Care

The second panel discussion explores equity of access and treatment.

Delores L. Parron, *Moderator*

Delores Parron, M.D., became Deputy Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services in 1999. She coordinates HHS-wide policy development, policy information, and policy support systems. From 1983-1999, she was Associate Director of the National Institute of Mental Health, and Director of the Office for Special Populations. Before coming to NIMH, she was Associate Director of the Division of Mental Health and Behavioral Medicine at the Institute of Medicine National Academy of Sciences. Her career in the mental health field has encompassed policy, research, teaching, and clinical work. Dr. Parron earned her doctorate at the Catholic University of America in Washington, D.C.

I want to begin with a personal anecdote. In 1976, shortly after President Carter was elected, I was in the last phase of completing my doctorate. One of my professors asked what I wanted to do beyond continuing to teach behavioral sciences to medical students at Howard University College of Medicine. My response was, " I would love to work with Mrs. Carter on the new President's Commission on Mental Health." Fortunately, I got my wish and it changed the course of my career.

The President's Commission was unprecedented in the way that it energized the mental health field. From promoting innovation in treatment for individuals who are seriously and chronically mentally ill to encouraging multidisciplinary research agendas and, especially, to consideration of the concerns of racial and ethnic minority individuals seeking assistance in the mental health care system, the Commission opened opportunities to explore new approaches that had real potential for expanding access to appropriate service.

Our theme of this symposium—culturally competent mental health care and access is a testimony to the progress that the field has made since the President's Commission on Mental Health.

Recognizing the emergence of dramatic shifts in the roles of women and the growing ethnic diversity across the country, the Commission designated one of its study panels as: Special Populations: Minorities, Women and the Physically Handicapped. The President's Commission on Mental Health was at the leading edge of change in doing so.

One of the themes that emerged in the work that we did was that while each ethnic— or gender or geographic—group has its own particular needs and interpretations, one area of common ground is abundantly clear: one size does not fit all when it comes to providing mental health services. This principle has stood the test of time and empirical analysis. In the mental health field, it is an essential standard for ensuring the highest quality of services to all people.

The presentations of this group of experts highlight important insights to guide the work of the mental health community toward continuing efforts to reduce stigma associated with mental illnesses and disparities in mental health care associated with racial, ethnic, and cultural minority status.

The Culturally Competent Context

Carl Bell, M.D.

Carl Bell, M.D., is President and CEO of Community Mental Health Council and Foundation, Inc. He is also Director of Public and Community Mental Health and Clinical Professor of Psychiatry and Public Health at the University of Illinois.

I have no idea what cultural competence is. I know I am Black. That is clear to me. I have been Black for a long time, so I may be culturally competent to deal with most African Americans. Perhaps not all, though, because there are many different levels of racial identity among African Americans. Some are pro-White and anti-Black; some are pro-Black, anti-White; some say, "Race and ethnicity doesn't matter; the only thing that matters is competence and money." Others believe people are people, but they support African Americans for political, social, and economic reasons. As a result, you have to approach people in different fashions.

That seems to me a critical piece of this puzzle.

I remember going to my dermatologist casually dressed. The European American receptionist asked me for my public aid card. I said, "What is it about me that makes you think I have a public aid card; why don't you think I run a $16 million dollar mental health center and have Blue Cross?" Those sorts of "micro-insults" and "micro-aggressions," as they've been called, keep African Americans, and women, and other ethnic groups off balance. But we have no scientific information about how those micro-insults and micro-aggressions wear us down.

Chester Pierce, the researcher who coined the terms "micro-insults" and "micro-aggressions," talks about the confusion that African Americans experience as a result of them. There is the confusion about when, where, and how to fight those insults — if you say something back to someone like that receptionist, as I did — you are in danger of being labeled "oversensitive" and you may walk away feeling worse. There is

confusion around whether you are being accepted or tolerated. Dr. Pierce talks also about the confusion that results in Blacks' attitudes toward White folk of good will, as a result of Whites' collective negative impact on people of color.

Those kinds of dynamics can make African Americans feel unwelcome when they go for services of any kind, including those for mental health. I was recently in South Africa where the rate of HIV is sky high. The black Africans are convinced the white Afrikaners have put the virus in the condoms, so they're not going to use them. We see a similar thing here: a group of mostly crazy European Americans telling Black folk that there is a genocidal plot to put all Black children on Ritalin and Prozac. Of course, these people are knuckleheads. But Blacks are reading this information on the Internet and not putting their children on Ritalin. I say to people, "If it's a genocidal plot, help me understand why in Maryland and North Carolina, there are three times as many White children on Ritalin as Black children. Do White folk want to kill their children, too?"

It boils down to an issue of trust. And a lot of people out there are telling Black folk they should not be trustful.

Cultural Reponses

Another example of cultural sensitivity is illustrated by this story. An analyst was treating a Catholic priest who was having obsessive thoughts about sex. The analyst said, "Freud tells us the thought is not the act." The Catholic priest said, "But I'm Catholic." The analyst said, "What difference does that make?" The priest said, "For me, the thought is the act."
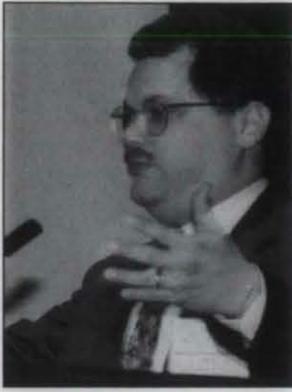
We need studies that asses the effectiveness of using the cultural formulation as opposed to a non-formula, non-cultural formulation type of treatment in clinical care, including their cost-effectiveness.

emotional state through receiving respect and support from family members. The overall causes of her nervios, she said, were recurrent family conflicts and losses; she also mentioned a "spiritual" alternation that left her "weak." That was why the perceptions —celajes (glimpes) and noises—were bothering her. When asked: "Do you want to go to a spiritual healer?," she replied, "I don't believe in that," preferring instead medical intervention and highlighting the complexity of many patients' help-seeking choices. She had many of the symptoms, but did not have a commitment to folk healing.

Her main explanatory model of illness was that she suffered from an anatomical alteration of the nerves; in her mind, a physical component accompanies the emotional one. Therefore, if the doctor's examination does not include x-rays or other searches for physical causes, the patient may lose confidence that the illness is actually being treated completely and carefully.

During this patient's lifetime, x-rays as a diagnostic test for tuberculosis had reached Puerto Rico; this illness was a scourge on the Island. In her view, and that of many other Puerto Ricans, if x-rays can discover "air problems" in the lungs, why could they not pick up changes in the nerves?

Her health-seeking experiences followed a logical pattern for nervios complaints. She first went to a primary care clinic, since she felt her illness was due to an alteration of her nervous system. The clinician referred her to a psychiatrist, whom she came to accept as the "specialist of the nervous system."

The next part of the formulation examines the patient's psychosocial environment and disabilities. Her past traumas included an alcoholic father; separation from four of her five children when she migrated to the United States to escape an abusive husband; poverty, discrimination, and the murder of

her second husband; family estrangement. Her social support system was precarious and she was constantly afraid of losing her government subsidies.

With this information, it was possible to assess the relationship between the patient and the clinician. The woman's inpatient unit had a Caribbean psychiatrist who spoke Spanish; interpreters were available when needed. Attention was paid to ethnicity, but insufficient attention was paid to culture. And those terms are not synonymous. You need both for effective treatment.

When she left the inpatient unit without much improvement, the outpatient service used the cultural information from the formulation to rediagnose her. Her new treatment included family therapy—a kind of "day hospital" at a daughter-in-law's home— and a doctor's supervision but no medication. And over the past eight years, her progress has been significant.

The cultural formulation is a method of creating cultural competence. In the process of a clinician doing a formulation, he or she and the patient will not only reach a good rapport, a better rapport often occurs, and the clinician also will gain the knowledge base that is needed to effectively treat others from cultural backgrounds with which he or she is unfamiliar.

At Columbia, we are using the Cultural Formulation to train third-year residents in diagnosing patients.

We now need studies that assess the effectiveness of using the cultural formulation as compared to a treatment that is not based on cultural information, including evaluation of the relative cost-effectiveness of the cultural approach. These studies would encourage the interaction of cultural psychiatry and psychology with other researchers in order to make the Cultural Formulation a more integral aspect of diagnosis and treatment.

The Civil Rights Context

Kathryn A. Ellis

Kathryn A. Ellis, J.D., is Principal Deputy Director, Office for Civil Rights (OCR), U.S. Department of Health and Human Services in Washington, D.C.

As we explore how best to provide access to mental health services for people of color, it is important to see this issue not only as a health issue, but also as a civil rights issue. There are protections under the law, in particular under Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act, to ensure that those who seek mental health services receive such services free from discrimination based on how they look, how they speak, their national origin, or their mental health status.

Thus, the issue of access to mental health services can and should be explored through a civil rights prism.

Background Briefing

Talking about civil rights and potential discrimination makes some people tense and uneasy. They assume intent. But when we talk about discrimination, we do not assume intent. This is not to say that intentional bias does not affect an individual's ability to access health care; sometimes it does. More often, however, discrimination is unintentional and subconscious. It may occur due to a lack of information or an unawareness of the law. In either case, it is still a problem to be addressed.

In the Office of Civil Rights, our job is to ensure that individuals are not discriminated against, whether intentionally or unintentionally, when trying to access health and human services programs supported by the Department. We are, in essence, a law enforcement organization, responsible for enforcing Federal civil rights laws that pertain to race, color, national origin, age, disability, and gender.

Our enforcement responsibilities extend to thousands of hospitals, state and local agencies that provide welfare benefits, nursing homes, mental health centers, private providers—the breadth of health and human services providers funded by our Department. We have a nationwide staff of approximately 220 people, the majority of whom are in ten regional offices across the country, so wherever you are, you can reach us. If you suspect that someone is being discriminated against in his or her effort to access mental health services, please give us a call.

The Office of Civil Rights—and its counterparts in other Federal agencies—is one of the few places in the Federal government where individuals can go if they feel they have suffered discrimination. We will investigate that complaint of alleged discrimination, seeking to understand if, and why, discrimination has occurred.

We also initiate compliance reviews if we have reason to believe there may be a violation of the law that we enforce. Compliance reviews have been sparked by newspaper articles or calls from individuals, organizations, and health care providers themselves. If a violation is found, we first seek voluntary compliance with the civil rights laws by the recipient. Many times a phone call from OCR informing a recipient of a violation is enough to rectify the situation. Our ultimate sanction is to terminate a recipient's federal funds; that is our "big stick."

However, before using that, we would work diligently with the recipient to develop a corrective action plan. We know that working in collaboration with state and local partners, advocacy groups, health providers, associations, and others on the

For many individuals whose primary language is not English, language is a barrier to communicating effectively with their clinician.

front end is the most effective way to serve the public.

Accordingly, we are doing more outreach to help people understand the parameters of the civil rights laws, and to let them know that we exist. We are attending more meetings, workshops, and symposiums like this one because, with only 220 of us, we need help spreading the word that the civil rights laws protect everyone trying to access health care, especially the most vulnerable among us.

Mental Health, Civil Rights

Looking through the civil rights prism, we can explore how language can be a barrier to meaningful access to mental health services. Dr. Lewis-Fernandez has illustrated how important it is for a patient to effectively communicate with his or her clinician. In his case study, the Puerto Rican woman had a Caribbean psychiatrist who spoke Spanish, and interpreters were available to her when needed. There was attention paid to her ethnicity. As a result, Dr. Lewis-Fernandez was able to focus on a second, and important issue, her cultural orientation.

However, many individuals whose primary language is not English do not even make it to first base. For them, language is a barrier to communicating effectively with their clinician. This has been a tremendous problem, not just for the Latino community, but also for the Asian community and the multiple communities in our increasingly diverse country: if your limited English skills make it difficult or impossible for you to communicate with your health care provider, you are not being provided meaningful access to health care. Ineffective communication can lead to delay in services, denial of benefits, or misdiagnosis. The inability to receive language assistance from health care providers who receive funding

from the Department may also be a violation of Title VI.

In August 2000, OCR issued guidance to assist health and human services providers who receive funding from the Department to understand their obligations under Title VI to provide language assistance to individuals with limited English skills. Issuance of this guidance followed President Clinton's Executive Order 13166, in which he directed all Federal agencies to develop guidelines on how each agency would provide language assistance to beneficiaries of Federal programs. Our Department was the first Federal agency to issue such guidance pursuant to the Executive Order.

The guidance is not a new rule or policy; it is, however, the first time that OCR has synthesized the legal requirements that have been on the books and that OCR has been enforcing for 35 years. In sum, the guidance explains the requirements of Title VI and provides parameters on how to comply with these requirements, emphasizing flexibility in fashioning a language assistance plan.

Individual Tailoring

We recognize that there is no "one size fits all" solution for Title VI compliance. We do explain in the guidance that effective programs usually contain the following four elements: an assessment of the language needs of the population(s) to be served; a comprehensive written policy for oral interpretation and written translation; a staff training plan; and regular monitoring.

In the guidance, we also describe promising practices. Many in the health care community have been providing language assistance in a variety of ways for a long time. For example, in several parts of the country, both urban and rural, community organizations and providers have creat-

ed community language banks that train, hire, and dispatch competent interpreters to participating organizations. We share these promising practices in the hope that other health care providers may benefit from their experiences.

Involved, Proactive, Available

We realize this is only a beginning. At a Latino summit in Iowa recently, I was struck that many people knew individuals who had been turned away from a hospital that was unprepared to provide interpretive services.

I share this feedback as an illustration; there are probably hospitals in the same position in communities across the country. The hospital not only failed to appreciate its responsibility to provide free language assistance, but it also was unaware of various tools available.

The guidance attempts to remedy this, as well as highlight that OCR is available for technical assistance. OCR wants to partner with you in this effort to ensure that race, ethnicity, and culture are integrated into the way we provide mental health services. Towards this end, we are involved, we are proactive, and we are available.

The "Home Place" Context
David T. Takeuchi

David T. Takeuchi, Ph.D., is a Professor of Sociology at Indiana University, Bloomington.

Spurred by the civil rights movement of the 1960s and with a supportive federal government in the 1970s, many recommendations were advanced to meet the mental health needs of racial and ethnic minority communities. In recent years, there have been concerted attempts by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health (NIMH) to operationalize the meaning of terms such as "cultural responsiveness," "cultural sensitivity," and "cultural competence." While attempts to make these terms more meaningful and precise, it is essential to consider what lies at the core of cultural programs.

One of these essential core elements is the construct of "place."

Thomas Gieryn, a sociologist, has suggested the construct of place has three interrelated and essential features, each necessary but not sufficient alone. Place includes a geographic location that has boundaries and reference points. Place is a nexus where social life is initiated and engaged. And, finally, place is the holder of symbols, values, tradition, history, and a frame for organizing our experiences.

In essence, place is where someone feels he or she belongs. The opposite of place—being out of place—gives a sense of exclusion, divorced from the social symbols and social relations of the community. We can see the notion of place and how it is linked to race and ethnicity all across the American landscape. Native Americans are indigenous people who have been displaced from the spiritual resources of their land, their "place." African Americans were taken from their homeland, their "place," and brought to the United States in powerless

positions, which led to constrained opportunities for nobility. Latino and Asian Americans were often identified as alien or foreign and cast as strangers; their "place" elsewhere, they were excluded from the American identity.

Order and Place

Erving Golfman argued that people with a serious mental illness lose contact with their rituals and daily routines and interactions of daily life. They lose their place in society. When people with a serious mental illness seek treatment, the mental hospital or clinic often reinforces their disconnect with the established order. With ethnic and racial minorities, there is a double jeopardy, because, for the most part, they, in fact, are displaced or they are not seen as part of the American order.

The construct of place is important and offers insights for how community programs can be culture responsive, or sensitive to an individual's sense of place, by being attuned to a person's awareness of his or her place of origin, social identification, heritage, traditions. If we see the goal of all our culturally responsive programs as building place, as seeing the essence of making people feel they belong, it will go far in establishing quality care and better outcomes for people.

The Platinum Rule Context
Kinike Bermudez Walker

Kinike Bermudez Walker
is a consumer/advocate and
Executive Committee Treasurer
of the National Asian American
Pacific Islander Mental Health
Association.

Over the past 15 or so years, the word "consumer" has become much used in the mental health lexicon. In the business world, you are either a consumer or provider, and we are all consumers and providers.

I was diagnosed with bi-polar disorder nine years ago. I was born in Brooklyn. Until I was six, I thought I was Puerto Rican. I knew I was not White. I knew I was not Black. Everybody else was Puerto Rican.

What I learned, as I matured, was that my mother is from the Philippines; my father, also of Filipino, Hawaiian, and Chinese heritage, is first generation American, born in California.

But for all that, I still feel part Puerto Rican.

My Brooklyn community had a Jewish delicatessen on the corner; lox and bagels also were part of my culture.

My father was in the military, we moved around a lot. I grew up in Hawaii. Now I feel Hawaiian, too.

Consumer Empowerment

All that is to say that I probably know best who I am and what my cultural and social roots are. So I am thankful mental health organizations welcome and encourage participation of consumers. Consumers need empowerment, because we know best what works and what does not work within a cultural context.

I had to wrestle with my doctor about medication—I knew what was working, what was not. I wanted to be an equal partner in my treatment. So I kept a personal diary and I encourage other consumers to do

Education is important. We need to make sure that shame and stigma are addressed and that outreach efforts start to dispel the myths.

the same. If we truly are to be a partner in our recovery, mental health professionals have to listen to us.

And that means, does it not, they must speak our language, know our culture, beliefs, and traditions?

I have English as my first language. My mom, perhaps feeling inferior because of her accent and her limited English, forced her children to be American. I did not even know I was a person of color until 1986, when I was asked to serve on the board of a patients' rights advocacy group in San Francisco. The president said, "I would like to introduce Kinike. She is our first woman of color."

I was politically correct, even though I was not sure what it meant.

But I soon learned. Every time I went to a consumer conference, I was one of five, one of three. I was alone, representing "my people," and even though I was not hindered by language, I discovered the importance of language and the definite need for more representation for the monolingual, first-generation immigrants, the people who yet need to have a voice.

Values and Heritage

Shame and discrimination are still issues in the Asian-heritage population. When I say, "I honor my ancestors," and then I am a person diagnosed with manic depression/bipolar disorder, I do not want to admit my condition to anyone, much less talk about it to strangers. It is not within the framework of family to talk about personal matters with outsiders.

I experienced shame when I was diagnosed with mental illness. Before that, I was a teacher. A professional. A personnel director in a department store. I was the model minority. Then I am labeled with manic depression and told I may not be able to work. I may have to go on general assis-

tance. This eroded my confidence and self-esteem.

Discrimination still affects us. If I do not speak perfect English, you think less of me. If I do not say the right words, I am not educated. If I am unfamiliar with a local colloquialism, I am a foreigner. I carry my passport because of the number of times people have challenged my "Americanism." When I enrolled in college, I was asked to prove my citizenship. I said, "I was born in Brooklyn." But being born there and looking like you are born there are two different things. People see things from their perception.

Everyone wants quality of life. Family, home, work, a wholeness of body, mind, spirit. The promise of America, "freedom," is a hope all of us have. That is why my grandfather came here. But when you face discrimination because you're a different color, or you speak with an accent, that is not what my Vietnam-veteran dad died for. While anyone is oppressed, no one is free—absolutely no one!

Education is important. Families are important. We need linguistically appropriate, culturally sensitive educational material not only for families, but for communities. We need to make sure that shame and stigma are addressed and that outreach efforts start to dispel the myths.

Peer support is important. If I cannot talk to people who speak my language, I am isolated and displaced. We needed to connect.

Traditional healing practices are important. Part of traditional healing is that you do not kill the spirit. When you kill the spirit, you kill the person.

Remember, finally, that valuing diversity is not about the golden rule, which is treating others the way you wish to be treated; it is the platinum rule, which is treating others the way they want to be treated.

The Rural Context

Dennis R. Mohatt

Dennis R. Mohatt, M.A., is Vice President for Development at ABSolute Integrated Solutions.

In a lot of ways, we are like teachers in a segregated school advocating for better books. Our system, pure and simple, is discriminatory. It is separate. It is unequal. We do not have parity or even basic integration with the broader health care marketplace. Mental illness is not accepted as an illness without question. Providers of mental health care are treated as "suspect" by other professionals, and the people we work with to find healing also are not treated as equal. Just compare Hollywood's treatment of mental illness and mental health care, and you will get the picture.

What do you think about when you think about mental illness in America? What is your image? Do you think about a homeless person on the street, a victim of deinstitutionalization without after-care? Do you think about a consumer-run clubhouse or persons coming to a community mental health center on a bus or in a taxi? Do you think about a choice of provider? Do you think about a lawyer who is having problems? Or a friend at the office who has depression? Do you think about a businesswoman? What do you see?

Do you picture a farmer who's alone, depressed and suicidal after losing the family farm homesteaded by his wife's great-grandfather? Do you think about an itinerate psychiatrist travelling from town to town, available only once a month? Do you think about a three-hour round trip to the nearest clinic? Do you think about receiving care via a telehealth system?

Do you think about a Native American youth on a reservation being taken from his or her family and community, shipped off to a residential treatment facility or psychiatric facility four, five, six hours away

from home? Do you think about a migrant worker? Do you think about a refugee? Do you see rural America?

Rural mental health is a lot about being seen, and the challenges of availability, accessibility, and acceptability.

Reviewing the Facts

The bottom line is, are services and providers available? Can consumers reach providers and services? And can they afford them if they do? And are the services and providers what the consumer needs, and wants, and are they psychologically and culturally acceptable to them?

Here are a few facts.

• More than 60 percent of rural Americans live in mental health professional shortage areas. That figure has been consistent since the late 1950s, more than 40 years without improvement.

• More than 90 percent of doctoral level psychologists and psychiatrists practice and reside in metro areas. Where they live is important, because if professionals are not a part of the fabric of the community it makes the service that they provide even more foreign and suspect.

• More than 65 percent of rural Americans receive their mental health care from the primary care sector. Less than 20 percent of rural hospitals offer specialized mental health services.

The rural health insurance marketplace is a major player in accessibility. It is dominated by individual and small group purchasers, few of whom can afford, or choose to afford, behavioral health coverage. They simply don't have it in their policies. Medicaid coverage varies greatly from state to state because, of course, it is option-

> We see robust efforts by the federal government to support training, recruitment, and retention of rural primary care providers, while rural mental health is an afterthought at best.

al in the federal regulations; states can choose whether to offer it and what they offer in their package. Travel costs for providers and for consumers are usually not reimbursed. Rural programs often depend upon grants to meet service development needs, which limits sustainability.

Culture is rarely considered in the design and delivery of systems. We make mini-urban clinics in rural areas. We impose urban assumptions for care, and rural people suffer. Rural people often lack choice of provider, choice of service, choice of time, and even more importantly, the essential supportive resources to sustain recovery - housing, public transportation, support groups, vocational training, etc. Often in rural areas, those things don't exist. The fragile mental health infrastructure is left to create and support them.

Limits to Service

Accessibility and acceptability are just two of the barriers; other things also get in the way. Guild efforts often limit the scope of practice for non-doctoral providers. Guild efforts focus on the mainstream of the profession and, as a result, they push further and further away mid-level and other providers who serve rural areas.

For 25 years, Mansfield University—my alma mater—trained Masters-level clinical psychologists to serve rural areas. That program accepted its last class this year, because there is no longer a marketplace for a Master's level trained psychologist—that is the result of guild efforts to limit the practice of psychology to the doctoral level.

Guilds and accreditation organizations limit the utilization of generalists, pushing more and more for specialization. However, a generalist is often exactly the kind of professional that is needed in a rural environment.

Internship and residency standards limit the feasibility of rural site participation. Standards for internships often require a certain number of professionals to be "on the tile" at any given time while a person is in training, and do not accept direct supervision via telecommunication systems. In a rural environment, it is hard to meet that standard.

There also is a lack of federal support for the training and deployment of rural mental health professionals, which is not true in physical health care. We see robust efforts by the federal government to support training, recruitment, and retention of rural primary care providers, while rural mental health is an afterthought at best—rarely a focus.

Finally, there is a lack of rural competence at the public policy level. When I first became involved in rural mental health 20 years ago, I would go to Washington to meet with Representatives, Senators, and their staff. Almost always, I met someone in that process who had personal experience with rural life. That is no longer true. Their experience with rural America is often vacation experience, not family ties but leisure times.

Improving the Rural Landscape

Rural sustainability often rests upon a very few people who take the lead. When one or more of those people leave, a huge void opens. The "thousand points of light" in rural America, too often, are the taillights of people leaving town.

There are, of course, ways to improve mental health services for rural Americans. We need to increase federal funding for training professionals to work in rural areas and we need to broaden our definition of who those professionals are. We need to enhance support for the National Health

> **We need to provide opportunities that use unique rural responses and innovations. We do not need to force urban solutions.**

Service Corps to place providers in rural areas.

We need to develop initiatives to integrate and increase collaboration between community health centers and community mental health centers so that we are not supporting separate infrastructures in a fragile economic marketplace. We need to develop and sustain rural internships and residencies. We need to provide opportunities that use unique rural responses and innovations. We do not need to force urban solutions. We need to require rural impact analyses for all federal initiatives.

Before we develop a shopping mall, we do an environmental impact study. But when we develop a major healthcare policy, is anybody studying how it will impact rural America? How it will impact African Americans? Or Hispanic Americans? Or Native Americans?

As long as we continue to enact policies and regulations that are driven by majority need, we will continue to walk over minorities, including those who live in rural America.

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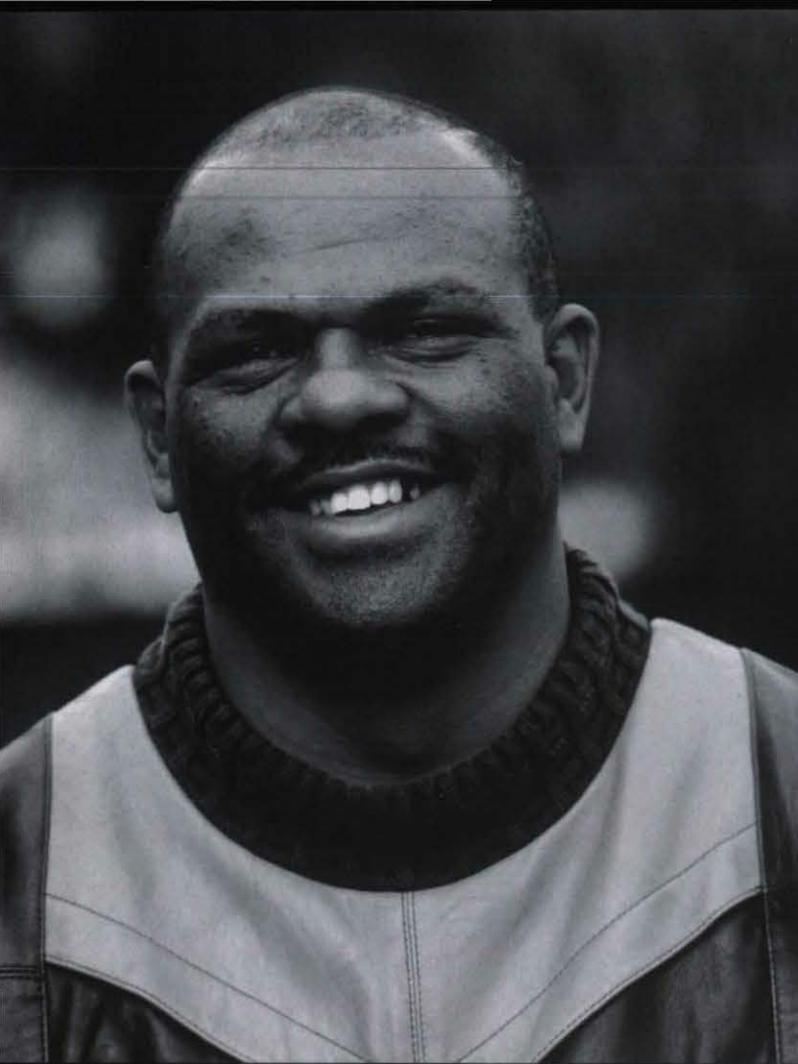
Partnerships in Action

The third panel discussion focuses on dissemination of report findings.

Michael English, *Moderator*

H ow can we turn the information we have learned into a tool that can be used to eliminate the disparities and take advantage of the cultural strengths that exist within communities, and thereby improve mental health for ethnic minorities in America? We could say, "Let's publish 10,000 copies of our findings. We'll put them everywhere. We'll also download a version on the Web."

But that is not an answer.

Dissemination in the classic sense is not an adequate vehicle for making change happen and for eliminating disparities. This requires an action agenda: strategies and commitment that result in real activity.

Exploring Traditional Channels
Richard Nakamura

Richard Nakamura, Ph.D., is Deputy Director of the National Institute of Mental Health and Acting Director for the Special Populations unit of NIMH.

T he Surgeon General, in his original report, said that mental health is fundamental to all health and that mental illnesses are real, diagnosable diseases of great burden in this country. Recovery is possible, he said, because treatment works. People who show symptoms should seek help.

In the minorities supplement to the Surgeon General's report, we add that mental illnesses affect all groups; they are not diseases of one particular population, but are universal in scope; and the source of disparities between Whites and minorities is not the distribution of mental-diseases across the cultural/ethnic group spectrum, but the access of those groups to treatment and to the possibility of recovery.

The problem of access relates to: provider behaviors, the huge discrepancies in the services that are available, the ability

of people to pay for services because of lack of insurance, and lack of proper siting of clinics. But lack of access also reveals itself within minority communities themselves, where a history of racism has produced distrust and stigma, including an unwillingness to recognize the mental illnesses that exist within minority families. This was true within my own family, for example, where bipolar illness was not discussed and even I was not told about the bipolar illness that occurred in my family until I was well beyond college.

Changing Behaviors
We need research to change both provider behaviors and behaviors of consumer groups. It is very, very important to eliminate the distrust if providers are to be able to provide quality treatment for everybody. Without doubt, minority and

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cultural groups cannot get proper treatment, or are very often misdiagnosed.

Even when properly diagnosed, they often are provided wrong medications and/or wrong treatment. We need to get that problem solved. It is not just a matter of providing the right face in the clinician, the right culture in the clinic, because even same-culture clinicians often seem to buy into whatever biases exist, and they, too, provide misappropriate treatment and diagnosis. We have a great need to figure out why this happens so consistently and what we can do to change the behavior of both providers and consumers.

As far as outreach is concerned, we need to avoid silos—our tendency to sit isolated on the landscape and fail to unite for stronger, more concerted, more effective communication. We need to avoid silos in minority communities, we need to avoid silos in treatment communities, and we need to avoid silos in government agencies. For too long NIMH and CMHS have acted independently and without consultation with each other; many other agencies have done the same. There is not enough discussion between the National Institute of Drug Abuse and the National Institute of Mental Health, for instance. Efforts are being made to change that, but more can be done.

We need to take advantage of our knowledge about how to change behavior to reach community leaders. Too often, they are the excluded individuals. We often talk of meeting with constituency groups, but it is the community leaders who have the influence to change thinking within cultures. We need to meet directly as peer to peer to advocate courses of action that get beyond our histories.

Traditional Channels

Finally, we need to educate, we need to use Web sites, we need to tap into regular media—television, newspaper, radio—channels, and we need to use publications like this one. We need to make them readily available for all Americans so that individuals can teach themselves the information they need and to ask the appropriate questions when they go to providers.

So, again, I ask that we try not to relive history, but to use this occasion to build, to move beyond the past and to really reach out in both directions for proper care for all Americans.

Partnering for Outreach
Marlene Echohawk

Marlene Echohawk, Ph.D., is Deputy Chief, Alcohol and Substance Abuse Program of the Indian Health Service.

The Indian Health Service is part of DHHS; we cover the country with 12 regional offices. We also are connected to the Bureau of Indian Affairs and work closely with the National Indian Health Board to determine priority areas in mental health. We also work with the National Congress of American Indians.

Recently, several agencies of us moved into one suite of offices in Rockville, Maryland. That alone goes a long way toward communication and dissemination of information.

How do we disseminate information externally?

In my Native American culture, the emphasis from the time we are born—even before birth—the rituals to greet the new-

born and to take care of the mother always stress prevention. So it is natural for me to say, "Let's go towards prevention; then we won't have to deal with the problems that have spent years and years getting worse and worse."

To get a handle on prevention, we are using our partnerships and networks of communication among agencies to combine our outreach into a behavioral health program, rather than alcohol here and mental health here and social service there.

And, having learned the value of working together, we hope other agencies will be willing to partner with us to get the information about mental health out to the largest possible number of Native Americans.

Talking to Communities
Pablo Hernandez

Pablo Hernandez, M.D., is the Behavioral Health Division Administrator for the Wyoming Department of Health, and the Administrator of Wyoming State Hospital.

Wyoming is a frontier state—and that makes it a challenging place to disseminate information about the Surgeon General's report, about the appropriateness of mental health treatment to ethnic/minority culture, and about other issues related to equitable services for minorities and language groups.

Here we drive miles and miles from community to community. It has not been easy to communicate with the stakeholders who may have never had a voice, the families and the consumers. Nor has it been easy to get our message to legislators who set policies and craft laws that never truly manifest cultural understanding and cultural appropriateness and sensitivity.

We have taken that challenge and driven thousands and thousands of miles, over the past two years, to conduct many town meetings—town meeting after town meeting. Getting out and speaking to people, in our frontier state, has signified a change in utilization of the Surgeon General's message about mental health services for children, adolescents, adults, and, most important, older Americans.

Multicultural Setting

When we talk about accessibility to care within the frontier state, we immediately think of the limitations language places on many of our citizens. Hispanics have been in Wyoming for 200 years; they now number 10 to 12 percent of the population. Many of the new arrivals are Spanish monolinguals.

Native Americans were in Wyoming before any of the rest of us. Many of them have lost their ancestral language, but they, too, represent a communications challenge for us in our efforts to disseminate information about mental illness.

And there is another special population that tests our ability to communicate —the deaf persons, the hard of hearing. Theirs is a unique world. You talk about trauma, culture, isolation, repression, abuse, and displacement. The deaf suffer all those.

Messages Defined by Audiences

We have targeted a number of issues for dissemination of information in Wyoming. Among the most important are a suicide prevention program, which contains

> Diversity can pull us apart, but diversity wisely and thoughtfully presented can also bring us together.

language elements, and a psychiatric advance directive, which helps individuals tailor their own treatments.

Wyoming, as well as the other Rocky Mountain States, has a very high suicide rate. To do something about it, we have interfaced with other agencies to promote inclusive policies and statutes regarding services for mental illness.

Our other initiative hopes to aid consumers in their choice of treatment. We asked, do consumers have a voice? How do they manifest that? We developed an assertive process of psychiatric advance directive so that people who only heard a monologue from service provides now have a choice for dialogue. Whereas before they were recipient of our directions, now they are party to decisions.

We also have looked at quality-of-life issues that have eluded many in Wyoming. We looked at human resource development that focuses on education and employment. Lack of fulfilling, significant employment can be a precursor to mental illness. People want to work. People need to work. We are uniting with other agencies to make sure people hear that message.

In that connection, a number of organizations have formed to bring us a multicultural perspective and a message of diversity; now they are presenting a unified form that creates a more likely process for

their voices to be heard. Diversity can pull us apart, but diversity wisely and thoughtfully presented can also bring us together.

Dissemination Plans

In summary, a quick review of our plan for dissemination includes these targets and actions:

Our number one action plan is about educating consumers, families, and communities. That is a very large task, a very large endeavor.

Number two, we are examining issues of accreditation and standards, regulations and human resource development.

Number three, we are working on prevention and on promotion of interventions that aid health.

Number four, we are seeking to improve and expand mental health services.

And number five, we are engaged in research on Hispanic Americans.

We have found in Wyoming that when we challenged people with facts, their response has been absolutely beautiful. Leaders have emerged, and people have expressed a commitment to consumer development, family development. Now, as we integrate our system of care—community system merging with service system—we foresee a better system of care for all the people of Wyoming.

Marsha Lillie-Blanton, Dr.P.H., is Vice President of the Henry J. Kaiser Family Foundation, where she directs policy research and grant making on access to care for vulnerable populations.

Tailoring the Message
Marsha Lillie-Blanton

Our healthcare systems, both physical and mental health, are truly at a crossroads; the increasing demographic shifts in our nation reveal that technical competence, which we have a lot of, is absolutely essential, but it is not all that is needed. Understanding that means we have to transform the systems of service delivery

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that serve very diverse populations.

Unfortunately, most Americans are at the very, very beginning level of that understanding. For the most part, the public and our systems are in almost a state of denial. We know there are issues to be addressed, but we are not quite ready to admit the problems are severe; we must address them and take action to do something about them.

How do we move our people and our systems from relying solely on technical competence toward a vision of a more holistic and unified approach to healthcare?

Many Sizes for Perfect Fit

It has been said often that one size does not fit all. That applies not only to caregivers and the populations to whom they give care, but also to those who need to hear our message.

If we are trying to convince the middle-aged Whites, if we're trying to convince providers, if we're trying to convince payers that there is a problem in our system, we must realize our communication may not work unless we vary it, because each of these "publics" varies in how it absorbs a message and in terms of what it expects from a message.

Take providers, for example. Neither clinically trained providers nor other types of providers want to be talked down to. They are trained. They are skilled. And they are licensed. Communicating facts in a way that providers understand and recognize and appreciate it is important. Otherwise the message is lost.

Tailoring your message depending on whom you are approaching is important. Language is only one part of understanding how to communicate. But understanding language is an important beginning and absolutely essential to success. People hail from multiple ethnic and cultural lives and

backgrounds. That also has an impact on how you approach an audience, because multiple backgrounds means multiple perspectives, and reaching out to those different perspectives is very important when you are trying to communicate a message.

Clarify Content

The evidence about disparities in care, in physical healthcare and mental healthcare, is only now beginning to emerge. It is not as if we did not know that there were differences. It is just that the research, the analysis, the documentation, the facts are only now coming to the fore. There are still many unanswered questions, trying to understand what factors shape the differences.

Your message has got to be clear: while we do have beginning facts, a preponderance of facts in some areas, not being able to answer the question of why creates a barrier, in some cases, to developing and taking action to address them. So you have to make sure people know what is known. You cannot assume there is a common level of understanding.

A Kaiser Family Foundation survey last year revealed most Americans, including most minority Americans, do not realize differences exist in the quality of care received by minority populations and the White majority. Most Americans realized that Blacks, for example, fared poorer than Whites on infant mortality or life expectancy, or that Latinos were less likely to have health insurance. We who live in health environments have a very clear understanding of those kinds of facts. But the general public does not.

Just as you cannot assume that everyone has the same level of understanding, you cannot assume your message is static. Ongoing research is essential. Facts are important. But research to help us know

> Information analysis—assessment of the effectiveness of different dissemination tools—is just as critical in communication as scientific research itself is on the problem.

what works well in communicating either the problem or its solutions is also important. That kind of research and information analysis, that assessment of the effectiveness of different dissemination tools, is just as critical as the research itself on the problem.

The Value of Trust

The message needs to be delivered by someone or some entity that is respected—and trusted—by whatever community you are trying to reach. There is a lot of distrust on the part of the general public. As you try to communicate a message about a problem, develop partnerships with and within communities you are trying to reach and find leaders who are respected, whose opinions are valued, and who are trusted. This will be critical to making sure that that message is received.

Developing partnerships goes even further.

For someone who has worked both at federal and state levels, I find it amazing how well we can all work in our own boxes, but how difficult it is to work across those boxes. In many cases, the communities we serve do not live in only one box. They face multiple problems, they live in many boxes. For us to work across boxes increases our potential to reach whole communities—provider communities as well as the consumer communities. And that dissemination principle is true for private sector organizations as well as government agencies

When possible, use channels within institutional settings—ombudsman's offices, grievance offices—to communicate your message. In some cases, the consumer may be the best advocate, because he or she understands what is going. Empowering that person to speak for him- or herself can be an important tool in addressing and reducing the disparities in care.

Another axiom: Do not be afraid to use the media as a partner. Media partners can carry our message much wider, much broader, sometimes with a much more compelling force than we ever could. Reaching out to that broader network is a strategy that can be intimidating, because we fear the message may be twisted or not presented in a balanced way. But media have the capacity to reach broader numbers than any of us can.

Blending Policy and Message

The Kaiser Foundation has been effective in communicating its messages, we believe, because we have both policy research and media/public education staff within one house. We have a senior vice president in health policy and a senior vice president in media and public education. I am lodged within the policy section, but I work closely with people in media and public education.

What happens, you will find, is that different kinds of skills, different kinds of mindsets, are needed. Some are more creative than others; some have a better grasp of numbers than others. I benefit from working with people who have a broader sense of how to reach out and spread a message. And so will you.

To cross-fertilize ideas among people who are developing the research and the findings on the problems, testing what works, and conveying the messages gives you a much better chance to produce messages that will communicate effectively with your target audiences.

We have tackled effectively many problems in our health care system. Understanding diversity and addressing the needs of a diverse population is one more that I think we can tackle—and solve—as a nation and as a healthcare system.

Working with Communities
Marguerite Ro

Marguerite Ro, Dr.P.H., is an Assistant Professor at Columbia University's School of Public Health and School of Dental and Oral Surgery and a consultant with Community Voices, W.K. Kellogg Foundation.

Trusted messengers are one of the most important components of effective communication. And trust comes through relationships.

One thing we have learned in working with state legislators and policymakers is the importance of trust. Relationships do not form just by disseminating information you think they need to know; it also comes from listening; from being reliable; and from responding, time and time again, to their requests. That lesson is particularly important as we embark upon a mental health campaign: the importance of relationships [within and beyond the mental health field] cannot be overstated.

A second rule in effective communication is to define your words carefully and intentionally. The best example is the word "community."

"Being part of a community" ... "reaching a community"—we use those phrases repeatedly. But what do we mean? The reality is each of us is part of many different communities. What "community hat" you wear on what particular day will greatly influence what you hear, what you understand, and what you believe as a result. Each community has its own particular set of values, experiences, and knowledge. How I would tailor a message that goes out to a "community" of legislators is very different from how I would tailor a message that goes out to a community of African American or Hispanic American parents versus a community of educators or providers.

To disseminate the Surgeon General's reports in a broad manner, we need to tailor messages to reach many different audiences. We need to talk about mental health in relation to general health. We need to talk about mental health in relationship to economic development. We need to talk about mental health in relation to education. These linkages can draw us together and help create a community that is actively concerned about mental health.

Community Voices

Community Voices" models one way of disseminating messages. Community Voices is a five-year initiative by the Kellogg Foundation. It involves 13 community collaborations across the United States. Each of our sites varies by its partnerships, but we ask all to develop a wide range of partners: academic institutions, health departments, community organizations, and so forth.

Our challenge is to improve access to health care for the underserved and uninsured. Each site addresses issues of mental health along with those of oral health, physical health, and so on. Our community collaborations are not formed around mental health. They are formed around improving health care for the underserved.

These sites are being challenged to integrate mental health into their more broadly based efforts to improve access to care. To do so, they are asked to reach out to the mental health community and to understand and translate the language of mental health providers and researchers in the field. The idea here is to build linkages between the mental health community and others who have traditionally addressed mental health.

Community Voices is a national initiative, as well as a local initiative. We understand that for us to make changes as a nation in addressing mental health, we have to have a movement that is both "bubble

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> Our local initiatives have been successful because they have employed local leaders who tailor the messages for their specific communities. We have experts who work one-on-one with them.

up" and "trickle down."

One reason our local initiatives have been so successful is because they have employed local community leaders who tailor the messages for their specific communities. We have researchers and policy and communication experts who work one-on-one with them. When these community leaders go out, armed with a thorough understanding of the message, they are effective messengers.

They also are key players in developing the strategies and plans for both the local and national efforts to improve access to mental health services. We turn to them for recommendations and advice on which direction to proceed. We rely on them to give us insight about where people are [in their beliefs and understanding], because if that is not our starting point, our message will go unheard.

So recognize your various communities and tailor your message to their interests, concerns, traditions, beliefs, hopes, and aspirations. Work with those communities, and they will work with you.

Discovering the Commitment to Service
Michael English

> We want to focus on opportunities and solutions.

Simply put: The Center for Mental Health Services seeks to communicate messages that stimulate action resulting in improved services for people, especially people who are most in need.

But how is this done?

Maybe specific examples will illustrate our approaches.

First, we have learned that we have to listen very carefully to our constituents; we are seldom right when we guess about their needs and wants. Listening is key in our organization.

Second, we have learned people speak best on their own behalf. We, therefore, are doing a number of things to help people of color make their own voices heard.

Third, we have learned we cannot do it alone. It is not a question of just finding partnerships, it is that we are not one of the respected messengers; we recognize that, we understand it, and we are taking steps to employ channels—messengers—that make our message respected and understood.

Fourth, we have learned community change agents need our support. Not to try to make the change happen ourselves, but to help those people who are going to make change happen by giving them the tools and the information they need. We want to promote the policy dialogue and we want to focus on opportunities and solutions.

Finally, we have learned to be flexible enough to change our strategy and our approach when somebody comes up with a better idea.

Empowering People

With respect to specific actions, we are proud of several things that have been done, including "consumer voice." To us, giving people their own voice includes, and in fact encourages, offering opportunities for consumers and families to speak out in forums that inspire development, diversity, and decision-making.

That is why we supported the meeting of AAPI's at the Alternatives Conference, where we experimented with a group speaking in 12 languages and had a tremendous

> It is extremely important to go where the vulnerable populations are. Over-representation in foster care and criminal justice and homelessness is one of the great American tragedies. We sponsor activities designed to deliver services to vulnerable populations.

learning experience. We supported the Hispanic Congress for Mental Health; we went out of our way to make sure consumers and family members had a strong voice there.

We know there are many things still to do. We need to ensure that all voices get a chance to be heard and to make sure we provide opportunities for all groups to collaborate. Because the promulgation of cultural competence standards are important, it is essential for us to help sell those standards to people who set standards for providing services and enforce those standards.

We need to provide resources for communities of color, so that they can build their own service capacity ... to give people the tools they need rather than do their work for them. We have a community action grant program to encourage sponsors or champions of exemplary practices to employ their activities in such a way they become community-owned and -adapted to meet the specific needs of the people who live there. Our Circles of Care program does the same thing for Native American communities with respect to children's services.

We feel it is extremely important to go where the vulnerable populations are. Over-representation in foster care and criminal justice and homelessness is one of the great American tragedies. We sponsor activ-

ities designed to deliver services to vulnerable populations.

Because we need to ensure a sensitivity to ethnic and cultural issues within our grant programs, we have review and award criteria to deal with issues of cultural awareness. Our programs require cultural competence. And we provide for the engagement of ethnic minority groups and their participation in both our studies and our knowledge application programs.

Seeking Partnerships

We are working to involve consumers and families of color in a meaningful way. Grant programs support and establish consumer and family networks in 37 states. We are seeking federal partners. Partnership is important. Talking about collaboration is one thing, but a real partnership involves the willingness of all the players to give up some of their own power. In one case—youth violence—we actually pooled financial resources with other entities. We gave up our authority over money.

To be partners, you have to give up your prerogatives in some respects and you have to engage in the development of shared commitments—that is what partnership is all about and that is what we are striving for.

Q/A
With
The Panelists

In our healthcare disparity research, we studied Black- and White-oriented women's magazines. The Black women's magazines were very, very different in quality and quantity of coverage, both in editorial and advertising content.

RICHARD NAKAMURA: Education is really fundamental. But some sources are not trustworthy. This is an area that needs more attention.

MARGUERITE RO: TV, newspapers, mag-

azines—they are our number one sources of health education and one thing we all should recognize when we think about our campaigns to disseminate the Surgeon General's findings, is the potential we have not only in free media exposure through articles, but also in media advertisements. We need to work with, for example, the pharmaceutical companies that put millions of ads now out there.

Activities and Actions

Reports of results and recommendations of the symposium work groups.

Group 1

Activities

- Well being of a diverse workforce and social fabric is critical to well being of America.
- Focus on wellness and building strengths in diverse groups.
- Reach people where they live.
- Training.
- Licensure/certification/continuing education.
- Private and public funding to build inclusiveness.
- Examine barriers to effective dissemination.

Actions/Products/Tools

- Create message using a culturally competent public health framework.
- Infrastructure: group and process to package message, process for delivery, to whom, and step-wise approach.
- Dissemination: massive and continuous media campaign/marketing effort to communicate about wellness in culturally and ethnically diverse groups, under auspices of the Surgeon General's office with partnerships.

Group 2

Activities

- Encourage target groups to develop summaries of the Surgeon General's report in their own voices and, in partnership with Surgeon General, develop a strategy for dissemination.
- Develop an effective media strategy that includes: (1) building on existing national mental health campaigns, (2) identifying media champions and trusted minority messengers, and (3) providing fact sheets in translated and alternative formats.

Actions/Products/Tools

- Promote increased funding for ethnic-specific research and promising practices in service delivery through government, industry, and private foundations.
- Link the Surgeon General's report with existing cultural competence standards for systems and build into accreditation.
- Link the Surgeon General's report with existing cultural competence standards for providers and build into credentialing.

Group 3

Activities

- National associations: convene a council of representatives from each organization to develop action plans.
- Strengthen minority participation within consumer groups.
- Advocacy organizations: disseminate the report through diverse media.
- Professional organizations: develop culturally competent training/continuing education programs.
- Businesses: hire/train minority clients with mental health issues.

Actions/Products/Tools

- CONVENE consumer/family/advocacy groups to develop national plan to address the mental health crisis in minority communities.
- ANNOUNCE national "Call To Action" to enhance Medicaid funding and close parity loopholes for mental health services.
- PROMOTE guidelines to improve cultural competence in all professional mental health training programs; service delivery, curriculum, internships.

Group 4

Activities
- COMMUNICATE: convene special meetings where report is presented. Invite speakers involved in report.
- EDUCATE: inform unintended health care providers for minorities, especially courts, jails, prisons, and grassroots organizations. Incorporate report in training of professionals.
- ADVOCATE: encourage business to develop standards that include cultural competency in health contracts.
- Create a list of minority-oriented resources.

Actions/Products/Tools
- Convene organization leaders to highlight findings.
- Provide materials with culturally sensitive scripts to facilitate organizations' tasks (communication, education, advocacy): camera-ready materials, web pages, audio, complete press package with language translations.

Group 5

Activities
- Coalitions (bringing together non-traditional groups).
- Cross-fertilizations.
- Training/education (school-based).
- Resource development (human and financial).
- Accessibility (availability, translation).
- Data collection/research.
- Annual meeting.
- Advocacy/rights protection/legislative.

Actions/Products/Tools
- Surgeon General appoint one person/contact point to respond to public requests and act as coordinator of report findings and develop information sharing templates.
- Create listserve and web site (with links to other resources).
- Create an Office of Health Disparities with a focus on mental health.
- Sponsor/convene groups/coalitions.
- Develop partnerships/activities to support dissemination and prevention.

Group 6

Activities
- Promulgate the message and incorporate into an agenda.
- Utilize consumers as spokespeople.
- Use Journalism Fellows/Carter Center to promote ongoing communication.
- Create a display to show Mrs. Carter's mental health work in The Carter Center Museum.
- Use association ethnic subgroups to help disseminate the message.
- Create a mental health component to CME that includes curriculum, licensing/credentialing requirements.
- Put forth research agenda.
- Use peer-to-peer networks.

Actions/Products/Tools
- Develop messages, fact sheets, tool kits.
- Influence research agenda at NIMH.
- Urge the Surgeon General to follow-up and remain a commanding presence in the field.
- Convene relevant government agencies to discuss and promote the message.
- Promote the Surgeon General's report with the World Health Organization report.
- Establish "Mental Health Fitness" program for youth and honors program for "star performers."
- Convene science forum for journalists.
- Charge professional organizations.

A Colorblind, Equitable Future

The challenges are also avenues of great opportunity.

Rosalynn Carter

Mental health is fundamental to general health; mental illnesses are real and they are treatable.

We in the mental health community know the tremendous need for adequate mental health care for all people. From our study of the Surgeon General's supplemental report, we have learned so much more about the barriers that particularly face minority individuals seeking treatment for mental illnesses. It is up to us and our organizations to raise public awareness and ultimately improve access to quality care that is ethnically appropriate and culturally sensitive.

It is a challenge, but it is also a great opportunity.

The Surgeon General's Report on Mental Health expresses our nation's concern for our citizens suffering from mental and emotional disorders. It provides an important resource for promoting acceptance of the facts that mental health is fundamental to general health, that mental illnesses are real, and that they are treatable.

The supplemental report enables us to more precisely focus attention on a traditionally underserved segment of our society. Our efforts here and the recommendations of our work groups will present specifications we can take to ensure that everyone, regardless of color or culture, can be treated and hold hope for a promising future.
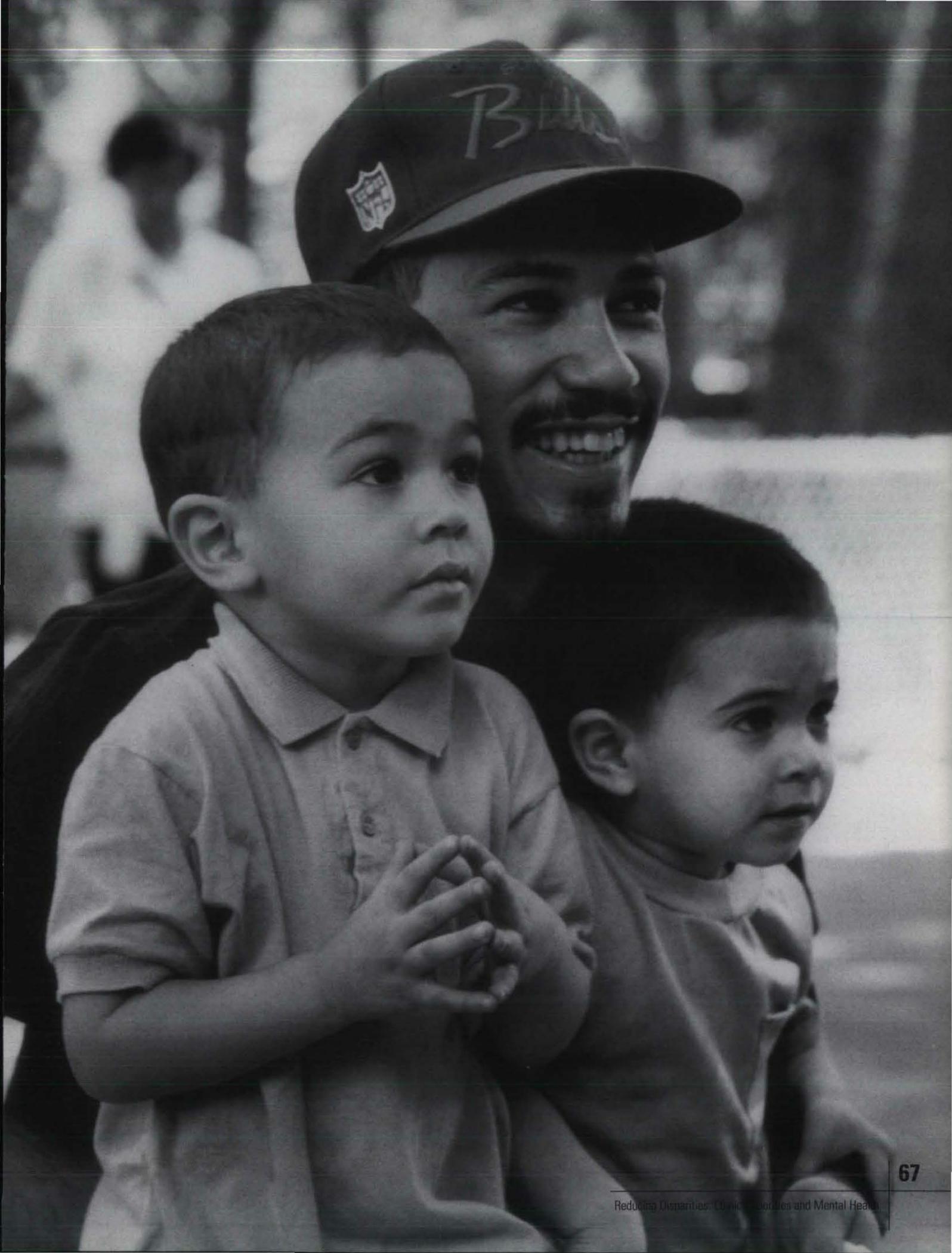
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