



Cultural Diversity Series:

**Creating Culturally Competent
Mental Health Systems for Latinos:
Perspectives from an Expert Panel**

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Preface

Disparities in access, quality and availability of public mental health services exist for racial and ethnic minority Americans, according to *Mental Health: Culture, Race and Ethnicity*, the 2001 supplement to the landmark *Mental Health: A Report of the Surgeon General* published in 1999. The call to provide appropriate and accessible mental health services to all persons—regardless of color, ethnicity, national origin, language, race, religion, age, disability, gender, sexual orientation and socioeconomic standing—challenges state mental health agencies to develop effective, culturally competent services and supports for an increasingly diverse consumer population.

This report, *Creating Culturally Competent Mental Health Systems for Latinos: Perspectives from an Expert Panel*, is the latest installment in the *Cultural Diversity Series* initiated by the National Technical Assistance Center for State Mental Health Planning (NTAC) to provide basic information and guidelines to public mental health agencies regarding the needs of a variety of ethnic and non-ethnic minorities. Each report in this technical assistance series provides a synopsis of the particular population's mental health needs, relevant cultural characteristics and traditions, perceptions about mental illness and preferences for services and supports. Each report also describes mental health programs that have successfully tailored their services to meet the needs of consumers from this population and contains a comprehensive resource section with recommended readings and organizational resources. Ultimately, the goal of the *Cultural Diversity Series* is to assist state mental health agencies in moving toward mental health service delivery systems that are appropriate and accessible to all consumers.

Other reports in NTAC's *Cultural Diversity Series* that have been published or are being developed address the mental health needs of African Americans; Asian Americans and Pacific Islanders; American Indians and Native Alaskans; persons who are gay, lesbian, bisexual and transgendered; and persons who are deaf.

Acknowledgments

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NTAC would like to express its appreciation to members of the NASMHPD work group that planned the panel discussion, selected panelists and guided the panel's agenda. Work group members included Dr. Hernandez, who also served as the panel moderator; Carlos Brandenburg, Ph.D., Administrator, Nevada Division of Mental Health and Developmental Disabilities; and Jose Canive, M.D., Associate Director of Clinical Psychiatry and Research, New Mexico Veterans Affairs Health Care System. Other contributors to the content and background of this report include H.C. (Hank) Balderrama, Mental Health Program Administrator, Washington State Mental Health Division; Nancy Delanoche, Program Manager, Office of Graduate and Undergraduate Education, American Psychiatric Association; Katherine Gordy Levine, M.S.S., Director, Mobile Community Support Team and Respite and Recreation Program, Visiting Nurses Service of New York; Rebecca Morales, M.S.W., Project Coordinator, Bronx Geriatric Program, Visiting Nurses Service of New York; Mary O'Brien, M.S.W., Clinical Services Manager, Behavioral Health Services, Yakima Valley Farm Workers Clinic; Jaci Ocegüera, Executive Director, Consejo Counseling and Referral Services, King County, Washington; Mario Paredes, Deputy Director, Consejo Counseling and Referral Services, King County, Washington; Dana Rusch, Research Assistant, University of Puerto Rico; Anderson Torres, Hispanic/Latino Program Specialist, Visiting Nurses Service of New York; Rick Ybarra, Director of Multicultural Services, Texas Department of Mental Health and Mental Retardation; and Luis H. Zayas, Ph.D., Director, Center for Hispanic Mental Health Research, Graduate School of Social Service, Fordham University.

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—*Catherine Q. Huynh, M.S.W., Assistant Director
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Introduction to the *Cultural Diversity Series*

The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences and assessing the mental health system's success in addressing cultural differences.

As the 21st century approaches, state mental health agencies face the growing challenge of accommodating an increasingly diverse and evolving constituency. The call to provide appropriate and accessible mental health services to all consumers—regardless of color, ethnicity, national origin, language, race, religion, age, disability, gender, sexual orientation or socioeconomic standing—challenges state mental health agencies to develop effective, culturally competent services and treatment methods. As the U.S. population changes dramatically, so does the public mental health system consumer base. Immigration is now the nation's major source of population growth. More than 1 in 4 Americans (27 percent) are non-white and/or Latino. By the year 2050, it is projected that nearly 1 in 2 Americans (47 percent) will be non-white and/or Latino.¹ Mental health staff may be unprepared for differences in language and world view, and even less prepared, for example, to support a gay inpatient consumer facing prejudice from other staff or residents or to provide crisis intervention to a deaf or otherwise disabled consumer. However, local and/or federal statutes may require appropriate service provision to these persons.

The *Cultural Diversity Series* attempts to provide basic information and guidelines regarding the needs of a variety of ethnic and non-ethnic minorities. Each of these technical assistance reports provides a synopsis of the particular population's mental health needs, relevant cultural characteristics and traditions, perceptions about mental illness and preferences for services and supports. Each report also describes several mental health programs that have successfully tailored their services to meet the needs of diverse consumers and contains a comprehensive resource section with recommended readings and organizational resources.

The goal of the *Cultural Diversity Series* is to assist state mental health agencies in moving toward mental health service delivery systems that are appropriate and accessible to all consumers. This report explores ways to develop culturally competent public mental health systems and services for the nation's Latino population. Future reports will focus on meeting the mental health needs of Asian and Pacific Islander Americans, American Indians and Native Alaskans, and persons who are deaf. The first two reports in this series, *Meeting the Mental Health Needs of African Americans* and *Meeting the*

¹ U.S. Bureau of the Census. (1996, May). *Resident Population of the United States: Middle Series Projection, 1996-2000 by Sex, Race and Hispanic Origin, with Median Age*. Washington, DC: Population Division, U.S. Bureau of the Census.

Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons, are available from the National Technical Assistance Center for State Mental Health Planning (NTAC).

Disturbing Service Utilization Trends

Despite their growing numbers, members of ethnic and racial groups are often underserved or inappropriately served by the public mental health system. Research suggests that various ethnic groups underutilize mental health services, either by dropping out of services or by entering services at much later stages in their illness, thereby creating a need for more costly services.^{2 3} For example, studies have found that although African Americans, Native Americans and Latinos/Hispanics in most states underutilize community-based services, they are significantly overrepresented in state inpatient facilities.⁴

Little is known about the patterns of utilization of mental health services by sexual minorities (gay men, women who are lesbian, and bisexual and transgendered persons). However, discrimination in mental health settings has been documented, as has the tendency of gay and lesbian youth (who are at high risk for substance abuse and suicide) to conceal their sexual orientation from health care providers.⁵ One major national survey found that 73 percent of respondents who are lesbian had pursued counseling services at some time, most frequently for feelings of sadness or depression.⁶

In anticipation of increased future service demands by growing ethnic minority populations, state mental health agencies are increasingly examining their accessibility to both ethnic and non-ethnic minorities. State mental health agencies may be able to reduce the use of costly inpatient services by engaging ethnic minorities during earlier stages of their mental illnesses. More important, by providing culturally competent community-based services to all minorities, mental health decisionmakers can minimize human distress.

² Lefley, H.P. (1990). "Culture and Chronic Mental Illness," *Hospital and Community Psychiatry* 41(3): 277-286.

³ Munoz, F. U., and Endo, R. (Eds.). (1982). *Perspectives on Minority Group Mental Health*. Washington, DC: University Press of America.

⁴ Aponte, H.J. (1994). *Bread & Spirit. Therapy with the New Poor: Diversity of Race, Culture and Values*. New York: W.W. Norton.

⁵ Gay, Lesbian, Bisexual and Transgender Health Access Project. (1997). *Health Concerns of the Gay, Lesbian, Bisexual, and Transgender Community*. (2nd Ed.). Boston: Massachusetts Department of Public Health.

⁶ Bradford, J., Ryan, C., and Rothblum, E.D. (1994). "National Lesbian Health Care Survey: Implications for Mental Health Care," *Journal of Consulting and Clinical Psychology* 62: 228-242.

Cross-Cultural Mental Health Services and Barriers to Service Delivery

Culture encompasses “the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group.”⁷ Cross-cultural mental health service delivery occurs whenever two or more of the participants are culturally different. Thus the term could be applied, for example, to “a counseling dyad consisting of a low-aculturated Mexican American client and a high-aculturated Mexican American counselor.”⁸ Similarly, a married heterosexual service provider brings a vastly different world view and set of experiences to the counseling relationship than a single client who is lesbian. Policymakers and service providers are coming to understand that cultural diversity must be broadly defined to accommodate wide variations among consumers.

Cultural differences exist on many levels, including help-seeking behaviors, language and communication styles, symptom patterns and expressions, non-traditional healing practices and the role and desirability of medical intervention.^{9 10} Members of ethnic and non-ethnic minorities may be underserved by the public mental health system for varied and complex reasons. Some commonly cited factors include:

- ◆ the stigma of mental illness and the varying ways that members of different ethnic minority groups may define mental health and mental illness;
- ◆ lack of culturally appropriate services to accommodate the needs and beliefs of diverse consumers;
- ◆ consumer fears of experiencing discrimination in the treatment setting;
- ◆ mental health providers’ lack of awareness or knowledge regarding culturally appropriate policies and practices;

⁷ Cross, T.L., Bazron, B.J., Dennis, K.W., and Isaacs., M.R. (1989). *Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Seriously Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Development Center.

⁸ Atkinson, D.R., Morten, G., and Sue, D.W. (1998). “Racial/Ethnic Minorities and Cross-Cultural Counseling.” In Atkinson et al. (Eds.) *Counseling American Minorities*. New York: McGraw-Hill. p. 17.

⁹ Comas-Diaz, L., and Griffith, E.E. (Eds.). (1988). *Clinical Guidelines in Cross-Cultural Mental Health*. New York: Wiley.

¹⁰ Gaw, A.C. (Ed.). (1993). *Culture, Ethnicity and Mental Illness*. Washington, DC: American Psychiatric Press.

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- ◆ language barriers increased by the growing numbers of both consumers and providers whose native language is not English;
 - ◆ communication barriers based on differences in verbal and nonverbal styles that may lead some minority consumers to feel they have given very clear messages to providers who have not understood the communication;
 - ◆ lack of familiarity with Western or mainstream mental health services;
 - ◆ fear of exposure or discomfort about disclosing sexual orientation or gender identity concerns to service providers; and
 - ◆ systemic barriers, such as funding sources that place strict limits on reimbursable services.

Special challenges may be present in the case of consumers who are refugees or whose native language is not English; both of these groups may exist within all of the communities addressed in the *Cultural Diversity Series*. For a fuller discussion of needs and barriers to service faced by consumers who are refugees or are non-English speaking, see the sidebars on pages 6-7.

Cultural Competence

Developing cultural competence within a mental health system is a dynamic and evolutionary process.¹¹ The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences and assessing the mental health system's success in addressing cultural differences. A culturally competent approach to services requires that agencies examine and potentially transform each component of mental health services, including assessment, treatment and evaluation.

Developing respect for differences and cultivating successful approaches to diversity requires increased awareness—of one's self; of unstated institutional cultural norms; and of the history, culture and needs of diverse consumers. To increase cultural competence, mental health service providers need to develop an awareness of their own racial and cultural heritage; to understand how that heritage influences their

¹¹ *Building Bridges: Tools for Developing an Organization's Cultural Competence* (see Miller et al. in suggested readings), the authors identify six stages of developing cultural competence:

- Stage 1 Sees other cultures as inferior: seeks to destroy other cultures.
- Stage 2 Cultural incapacity: adopts paternalistic posture toward so-called inferior people.
- Stage 3 Cultural incapacity: seeks to assimilate differences, ignore strengths.
- Stage 4 Cultural precompetence: realizes weaknesses and makes commitment to improve.
- Stage 5 Culturally competent: respectful, accepting, self-monitoring.
- Stage 6 Takes advocacy and educational role.

understanding and biases about normality/abnormality and the process of mental health service delivery;
and to understand the significant impact of differences

both in language and in verbal and nonverbal styles on the process of communication.¹² Mental health systems typically operate on unstated Western principles—such as, for example, the primacy of the individual over the group, a focus on competition and achievement, separation of the mind and body and devaluing of altered states of consciousness—which may be at odds with the underlying values and beliefs of some ethnic and racial populations. Without awareness of this dynamic, mental health providers may impose this Western framework on minority consumers.

The populations that are the subject of these reports have all experienced and/or are experiencing some form of social inequity that is directly relevant to their status as underserved groups. Exploring and sometimes challenging the assumptions and biases held by stakeholders and the wider community is a crucial step toward achieving a culturally competent system. These attitudes have a direct impact on the functioning of minorities, their mental health needs and their willingness to seek services. Similarly, cultural assumptions affect the mental health system, its practitioners and its ability to engage minorities.

Some mental health systems and providers seeking to increase cultural awareness may inadvertently rely on overgeneralizations that ignore subgroup and individual variation, thus belying the basic value of cultural competence. To be truly culturally competent, mental health systems must be aware of significant differences in lifestyle and world view among diverse populations, while valuing and responding to the distinct needs of each client. Rather than relying on stereotypes about groups, administrators and practitioners need to be aware of their own cultural assumptions and to ask consumers how *they* understand their problems and what *they* need.

These reports are designed to help key decisionmakers wrestle with the challenges facing public mental health systems, while effectively addressing the need for individualized, culturally competent services for ethnic and non-ethnic minorities.

¹² Atkinson et al., op.cit.

A closer look at: Refugees

People seeking refuge in the United States come from all ethnic and racial backgrounds and often have great difficulty obtaining traditional mental health services. These individuals have often experienced severe stress, resulting from continuous threat to life or freedom, traumatic flight, death of family members or friends, torture and imprisonment, living in concentration or refugee camps, uncertainty and lack of control over relocation and inability to return to their homeland.¹³ Their mental health may be jeopardized by multiple losses (of country, family, status) and other major disruptions (e.g., unemployment) which often accompany resettlement in a new country. A proportional number can be expected to be sexual minorities, or deaf or disabled, and the meaning and impact of these attributes will vary widely by culture.

Unfortunately, definitive prevalence rates of mental illness among refugees are elusive. The few studies available reveal that depression, anxiety and post-traumatic stress disorder are reported at disproportionately higher rates in refugee populations. In addition, a small percentage of refugees experience schizophrenia or brief reactive psychoses marked by delusional content strongly related to culture which may require prolonged, intensive intervention.¹⁴ Typically, SMHAs have contact with refugees during times of crises through crisis counseling services or inpatient treatment. Successful strategies to engage refugees prior to the eruption of crises include:

- ◆ networking with and through the refugee community;
- ◆ conducting home visits;
- ◆ linking with physical health services;
- ◆ using bicultural professional and paraprofessional staff; and
- ◆ making outreach efforts that focus on helping refugees meet basic needs, such as housing and income.

Such services are accepted more easily when linked with resettlement agencies (e.g., religious-based organizations, private organizations, state agencies or ethnic organizations that assist individual refugees upon arrival) and mutual assistance associations in which former refugees and immigrants help their own people. The Center for Mental Health Services' Office of Refugee Mental Health serves as a bridge between the mental health and refugee communities, providing consultation and training to states and refugee organizations.

A closer look at: Non-English Speaking Consumers

¹³ Garcia-Peltoniemi, R.E. "Clinical Manifestations of Psychopathology." In Westermeyer, J., Williams, C.L., and Nguyen, A.N. (Eds.) (1991). *Mental Health Services for Refugees*. Washington, DC: U.S. Government Printing Office.

¹⁴ Ibid.

The challenge of developing culturally competent mental health services is complicated by the vast number of languages that are spoken in the United States. Mental health providers may have difficulty reaching, communicating with and treating non-Englishspeaking and/or deaf consumers, who exist within all communities.

Ideally, bilingual mental health professionals will be available to engage and provide treatment to people whose primary language is other than English. However, the need for academically trained, multilingual and multicultural mental health professionals far exceeds the number now available. While increasing the numbers of these professionals is essential, other models of services are also in use, including:

***Bilingual Paraprofessionals.** While they may not have formal clinical training, bilingual workers serve many valuable functions, including translator, paraprofessional counselor, culture broker, outreach worker, community educator, community advocate and trainer of service providers about the refugee's culture.¹⁵ Ultimately, the goal may be to encourage bilingual workers to obtain further academic training in mental health to increase the supply of bilingual and bicultural psychiatrists, psychologists, social workers and other mental health professionals.

Interpreters. Using interpreters for assessments and treatment is a less desirable route, but one that many systems rely upon given the shortage of bilingual mental health professionals. As Adkins noted, "A facility with language does not make a person an effective interpreter unless there has been adequate training, agreement on interpretation system, and building of rapport between the mental health professional and interpreter."¹⁶ Thus, relying on family members to serve as interpreters is considered inadequate and inappropriate.

**Persons who can communicate in a spoken language and in American Sign Language are considered bilingual.*

¹⁵ Egli, E. (1987). *The Role of Bilingual Workers Without Professional Mental Health Training in Mental Health Services for Refugees*. Minneapolis, MN: Department of Psychology, University of Minnesota.

¹⁶ Adkins, M.A. (1990). "Role of Bilingual/Bicultural Service Providers in the Delivery of Mental Health Services." In Holtman, W.H., and Bornemann, T.H. (Eds.) *Mental Health of Immigrants and Refugees - Proceedings of a Conference Sponsored by Hogg Foundation and World Federation for Mental Health*, Austin, TX: Hogg Foundation for Mental Health.

Executive Summary

Introduction

Recognizing the challenges faced by state mental health agencies to provide culturally and linguistically appropriate services to its diverse constituency, the National Association of State Mental Health Program Directors (NASMHPD) recently turned its attention to the needs of Latinos, the nation's fastest-growing racial/ethnic minority population. At its Winter 2000 Commissioners' Meeting in Chandler, Arizona, NASMHPD invited a distinguished panel of experts on Latino mental health issues to discuss the demographic and cultural factors affecting Latinos' access to mental health services. Panel members included Sergio Aguilar-Gaxiola, M.D., Ph.D.; Margarita Alegria, Ph.D.; Javier I. Escobar, M.D.; Steven Lopez, Ph.D.; and Floyd Martinez, Ph.D.

As noted in the NASMHPD Position Statement on cultural competence, "Members of ethnic, racial, linguistic, and culturally diverse groups are often underserved or inappropriately served by the public mental health system." In response to these problems, the expert panelists shared the latest research findings on disparities in access to public mental health systems by Latinos and stimulated dialogue about how state mental health authorities can address disparities within public mental health systems, the meaning of cultural competence and initiatives to address gaps in care. They emphasized the importance of linking research findings with improvements in practice and policy.

Believing that the panel's important discussion should continue and reach additional stakeholders, the National Technical Assistance Center for State Mental Health Planning (NTAC) decided to publish proceedings of NASMHPD's informative panel as part of its *Cultural Diversity Series*. This report, *Creating Culturally Competent Mental Health Systems for Latinos: Perspectives from an Expert Panel*, reflects the panelists' presentations and follow-up discussion among participants at the Winter 2000 Commissioners' Meeting. Presenters' remarks have been woven into this report and attributed to the sources wherever possible.

Demographic and Cultural Characteristics

According to the 2000 U.S. Census, an estimated 35.3 million individuals, 13 percent of the U. S. population, reported that they were of Latino or Hispanic origin, making this group the largest ethnic population in the United States. The burgeoning U.S. Latino population encompasses people from 22 countries and a range of cultures who speak a wide variety of Spanish dialects as well as a number of different languages. Although many Latinos live in the West Coast and Southwest regions of the United States, the Latino population is growing significantly in every state.

These demographic, geographic and linguistic realities demonstrate that the demand for culturally responsive mental health services for Latinos is a national rather than regional phenomenon. Public mental health systems and staff need to be able to address differences in language, cultural perspectives, traditions, perceptions about mental illness, and preferences for services and supports among their diverse Latino clients.

Defining Culture

Panelist Steven Lopez, Ph.D., emphasized that culture is a complex and evolving concept that involves “values, beliefs and practices” along with social experience and daily routines. People are not passive recipients of culture but actively engage in sorting through myriad experiences and messages to identify what matters most for them, he noted. Thus the cultural experience of individuals and groups changes over time, contributing to considerable heterogeneity within any particular group.

Highlights of the Mexico American Prevalence and Services Survey

Several panelists referred to the Mexico American Prevalence and Services Survey (MAPSS), a landmark study of the mental health needs of Latinos in Fresno County, California. The following findings are among the study’s key conclusions:

- ◆ The most dramatic difference in prevalence rates for mental illnesses appeared to correspond with an individual’s place of birth.
- ◆ Mexican immigrants to the United States experienced about one-half the prevalence rates for major psychiatric disorders of either U.S.-born Mexican Americans or other U.S.-born individuals. However, they experienced mental disorders at about the same rate as residents of Mexico City (24.9 % and 23.4%, respectively).
- ◆ Mexican Americans born in the United States had roughly the same rate of mental disorders (48.7%) as the general U.S. population (48.6%).
- ◆ Mexican immigrants who had lived in the United States for fewer than 13 years exhibited dramatically lower rates of mental disorders than those who had lived in the United States for longer periods, especially for alcohol and substance use problems.
- ◆ Although 32.5 percent of Mexican Americans or other persons of Mexican descent who lived in Fresno County had one or more diagnosable mental disorders, 73 percent of this group received no services for their conditions.

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- ◆ While the MAPSS study indicates that Latino individuals may underutilize community-based mental health services, at least one other study found that Latinos had a higher rate of admittance to public inpatient facilities than Whites as well as a lower admittance rate to private psychiatric hospitals.

Culturally Competent Service Design

Panelist Floyd Martinez, Ph.D., discussed four fundamental elements needed to achieve culturally competent mental health services:

- ◆ Champions within state mental health agencies, nonprofit organizations, and other regional and/or county agencies.
- ◆ Standards for cultural competence that are clearly articulated in contracts and other agreements between funding agencies and providers and that include sanctions for nonperformance.
- ◆ Support from the public mental health system to enhance the capacity of community-based minority agencies to thrive in a competitive managed care environment.
- ◆ Collaboration between the mental health and school systems to address the mental health needs of a diverse youth population.

After the panelists' initial presentations, state mental health officials and other audience members had an opportunity to share their thoughts and experiences concerning cultural competence in mental health service delivery. Several of the strategies adopted by states reflected the elements outlined by Dr. Martinez. Examples of those strategies include:

- ◆ engaging in ongoing cultural competence training for clinicians and others who provide public mental health services and supports, and linking funding for providers to achievements in performance and outcome measures of cultural competence;
- ◆ providing increased funding for mental health services to the Latino community, establishing a state-level office of multicultural affairs and requiring the provision of culturally competent services and development of cultural competence plans in state contracts with mental health providers;
- ◆ developing an extensive statewide network of interpreters so that forensic institutions in rural areas can have access to culturally and linguistically competent staff; and
- ◆ creating intra- and interstate networks of providers and clinicians to obtain cultural and linguistically competent clinical consultation through teleconferencing.

Recommendations

The panelists urged mental health policymakers and providers to think broadly and boldly when tackling the difficult issue of cultural disparities in the public mental health system. Dr. Alegria urged state mental health agencies to take a number of steps including the following:

- ◆ Introduce payment mechanisms that reward increased participation and retention of Latinos in community-based mental health services and programs.
- ◆ Create bilingual/bicultural assistance programs that link community mental health centers with schools, churches and community-based organizations to provide mental health interpreters.
- ◆ Develop transitional health insurance programs that address the needs of Latino migrants or temporary workers.
- ◆ Establish clinician support networks, including the use of a consultation hotline, to avoid misdiagnosis and provision of inappropriate services.
- ◆ Assess public mental health access, treatment and outcomes for Latinos in comparison with White consumers.
- ◆ Evaluate factors that account for the dramatic geographical differences in the availability of specialty mental health services.
- ◆ Initiate a five-year prevention plan in collaboration with the public school system to reduce rates of depression, substance abuse and suicide ideation among Latino adolescents.

Panelist Sergio Aguilar-Gaxiola, M.D., Ph.D., recommended that research findings be translated into clinical applications through a process that involves a wide range of constituents. He offered several policy recommendations including mounting public education campaigns to create awareness of mental health issues associated with immigrants' adjustment to American society, disseminating information on the availability of and access to culturally competent mental health providers, ensuring that insurance coverage is available for mental health services, providing in-service training for primary health care physicians regarding screening and referral of Latinos who have mental health problems, and implementing and evaluating cross-cultural competency guidelines. Such strategies illustrate how research can become a springboard for increasing the responsiveness of state mental health systems to the needs of Latino consumers and their families as well as members of other ethnic and racial minorities.

Most important, the presenters emphasized the need for action, not more discussion, to create culturally competent mental health systems. Yet they also cautioned against taking simplistic, one-dimensional approaches toward cultural competence. Both presenters and participants suggested a number of specific strategies that public mental health systems can employ to begin to address gaps in the provision of culturally and linguistically appropriate mental health services to Latinos and other ethnic and cultural groups.

**Creating Culturally Competent Mental Health Systems for Latinos:
Perspectives from an Expert Panel**

Proceedings of a panel discussion at the
National Association of State Mental Health Program Directors
Winter 2000 Commissioners Meeting

Panel Members :

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Introduction

Recognizing the challenges faced by state mental health agencies to provide culturally and linguistically appropriate services to its diverse constituency, the National Association of State Mental Health Program Directors (NASMHPD) recently turned its attention to the needs of Latinos, the nation's fastest-growing racial/ethnic minority population. At its Winter 2000 Commissioners' Meeting in Chandler, Arizona, NASMHPD invited a distinguished panel of experts on Latino mental health issues to present on the demographic and cultural factors affecting Latinos' access to mental health services and lead a discussion about how state mental health authorities might respond.

A NASMHPD workgroup comprising Pablo Hernandez, M.D., Administrator, Mental Health Division, Department of Health, Evanston, Wyoming; Carlos Brandenburg, Ph.D., Administrator, Division of Mental Health, Carson City, Nevada; and Jose Canive, M.D., Associate Director of Clinical Psychiatry and Research, New Mexico Veterans Affairs Health Care System, Albuquerque, New Mexico, selected the experts and shaped the panel's agenda. Panel members included Sergio Aguilar-Gaxiola, M.D., Ph.D.; Margarita Alegria, Ph.D.; Javier I. Escobar, M.D.; Steven Lopez, Ph.D.; and Floyd Martinez, Ph.D.

As noted in the NASMHPD Position Statement on cultural competence, "Members of ethnic, racial, linguistic, and culturally diverse groups are often underserved or inappropriately served by the public mental health system."¹⁷ Consequently, the experts shared the latest research findings and stimulated dialogue about how state mental health authorities might address disparities within public mental health systems. Panelists presented research data on the disparity in access, availability and appropriateness of mental health services, explored the meaning of cultural competence and discussed initiatives to address the gaps in care. They emphasized the importance of linking research findings with improvements in practice and policy.

Believing that the panel's important discussion should continue and reach additional stakeholders, the National Technical Assistance Center for State Mental Health Planning (NTAC) decided to publish proceedings of NASMHPD's informative panel as part of its *Cultural Diversity Series* exploring the mental health needs of ethnic and cultural minorities. *Creating Culturally Competent Mental Health Systems for Latinos: Perspectives from an Expert Panel* reflects the panelists' presentations and follow-up discussion among participants at the Winter 2000 meeting. The presenters' remarks have been woven into this report and attributed to the sources wherever possible.

¹⁷ National Association of State Mental Health Program Directors. (2000). *Position Statement on Culturally Competent and Linguistically Appropriate Mental Health Services*. Alexandria, VA: NASMHPD. For full text see Appendix A.

The reader may notice that this report uses the term Latino to refer to the wide range of individuals who are of Spanish/Hispanic/Latino descent. While using a uniform term to enhance readability, NTAC acknowledges the great variety in terms and nuances that are present when identifying the Spanish/Hispanic/Latino population. As Dr. Lopez pointed out during a break-out session, the preferred ethnic-identification label varies among regions, communities, even families. For example, in New Mexico, many people prefer to be identified as “Hispanicos” because they consider their ethnicity tied to their Spanish heritage. Others prefer being called “Latino,” choosing to disassociate themselves from ties to Spain and Spanish conquerors. As Dr. Lopez emphasized, it is important to understand how both the community and individuals view and use such labels.

Demographic and Cultural Characteristics

Dr. Martinez presented compelling demographic information that illustrates the importance of attending to the mental health needs of the diverse Latino population. According to the U.S. Census Bureau, 35.3 million individuals, 13 percent of the U.S. population, reported that they were of Hispanic or Latino origin.¹⁸ Latinos now appear to be the largest ethnic minority population in the United States.

The burgeoning Latino population encompasses people from a variety of cultures who speak a number of different languages. Dr. Martinez reported that Latinos living in the United States come from 22 countries throughout the western hemisphere and that some of these individuals speak an indigenous language that is neither English nor Spanish. In addition, a wide variety of Spanish dialects are spoken throughout the U.S. Latino community. Examples of indigenous languages include a derivation of Nahuatl, which is still spoken in parts of the Yucatan Peninsula of Mexico and Central America; Zapotec spoken in Oaxaca, Mexico; and Quechua, which is spoken by large numbers of people in South American countries.

Although many Latinos live in the West Coast and Southwest regions of the United States, the Latino population is growing significantly in every state. The U.S. Bureau of the Census reports that from 1990 to 1999, the greatest proportional increases in Latino population occurred in Arkansas, Georgia, Nebraska, Nevada, North Carolina and Tennessee.¹⁹

These demographic, geographic and linguistic realities demonstrate that the demand for culturally responsive mental health services is a national rather than regional phenomenon and that the demand is growing throughout the United States. Public mental health systems and staff need to be able to address the differences in language, cultural perspective, traditions, perceptions about mental illness and preferences for services and supports.²⁰

Panel members presented additional demographic information to provide a context for understanding the Latino experience in the United States. Latino families are often larger in size than Non-Latino White families—the average family household size among the former is 3.92

¹⁸ U.S. Census Bureau. Overview of Race and Hispanic origin (table). March 12, 2001, www.census.gov/population/www/cen2000/briefs.html

¹⁹ U.S. Census Bureau. States ranked by Hispanic population, July 1, 1999 (ST-99-48) (table). August 30, 2000, www.census.gov/population/estimates/state/rank/hisp.txt

²⁰ NASMHPD. (June 2000).

individuals compared with 3.02 individuals for the latter.²¹ The Latino population also is relatively young. The median age of Latinos living in the United States is 26.6 years compared with 38.6 years for non-Latino White persons.²²

Dr. Alegria underscored the sense of crisis experienced by many Latino youth. The Centers for Disease Control and Prevention (CDC) Youth Risk Survey found a 10.7 percent attempted suicide rate among Latino youth, compared with a 7.3 percent rate among African American youth and a 6.3 percent rate for White, non-Latino youth.²³ Generally Latino youth have higher rates of suicidal ideation and attempts than White or Black youth.²⁴ Of Latinos over age 25, only 56 percent have graduated from high school and 11 percent from college compared with the national averages within the same age group of 83 percent high school graduates and 25 percent college graduates.²⁵

Dr. Escobar described some of the economic disadvantages experienced by many Latino individuals, indicating that they may contribute to mental health disparities:

- ◆ Latino households have a lower annual median income (\$30,735 in 1999) than White, non-Hispanic households (\$44,366).²⁶
- ◆ Latinos experience greater rates of poverty: the 1999 poverty rate for Latinos was 22.8 percent compared with 7.7 percent for non-Hispanic White persons.²⁷

²¹ U.S. Census Bureau. Growth in single fathers outpaces growth in single mothers, Census Bureau reports (press release). December 11, 1998, www.census.gov/Press-Release/cb98-228.html

²² U.S. Census Bureau. Resident population estimates of the United States by sex, race, and Hispanic origin: April 1, 1990 to July 1, 1999, with short-term projections to November 1, 2000 (table). December 20, 2000, www.census.gov/population/estimates/nation/intfile3-1.text

²³ Center for Disease Control (1997). Center for Disease Control and Prevention youth risk behavior survey - United States. *Morbidity and Mortality Weekly Reports* 47: No.SS-3.

²⁴ Center for Disease Control and Prevention. (1998). Youth risk behavior surveillance – United States, 1997. *Morbidity and Mortality Weekly Report* 47: 1-89.

²⁵ Newburger, E. and Curry, A. (2000). Educational attainment in the United States: Population characteristics, March 1999. *Current Population Reports P20-528*. Washington, DC: U.S. Department of Commerce.

²⁶ U.S. Census Bureau. Income 1999 highlights (table). September 26, 2000, www.census.gov/hhes/income/income99/inc99hi.html

²⁷ U.S. Census Bureau. Poverty rates by race and Hispanic origin (table). September 26, 2000, www.census.gov/hhes/www/img/incpov99/fig07.gif

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- ◆ A greater percentage of Latino children do not have health insurance than their White, African American or Asian American peers. These children include noncitizen Latino children (53 %); Latino children in immigrant families (29 %) and Latino children of U.S. born parents (16 %).²⁸

Although this demographic data can help mental health decisionmakers to recognize the breadth and complexity of the Latino population in the United States, the panelists cautioned that stakeholders should not use data and trends to make cultural assumptions that ignore the range of cultural differences (and similarities) that exist among individual consumers who are Latino and who participate in the public mental health system. In short, appropriate mental health services must still be individualized and flexible, accommodating each person's needs. The following section on "Defining Culture" provides ideas about how clinicians and policymakers can develop mental health services that strike the balance between recognizing an individual's broad cultural heritage and understanding his or her unique personality and relation to that culture.

²⁸ Brown, R., Wyn, R., Hongjian, Y., Valenzuela, A., and Dong, L. (1999). Access to health insurance and health care for children in immigrant families. In D.J. Hernandez (ed.), *Children of Immigrants: Health, Adjustment, and Public Assistance*. Washington, DC: National Academy Press.

Defining Culture

Dr. Lopez led the state mental health officials and other stakeholders through a discussion about defining and understanding culture and its implications for mental health service delivery. He emphasized that for culturally appropriate services to be offered to Latinos, service providers must have a solid understanding of culture. In particular, he pointed out the importance of comprehending culture as a complex and evolving concept.

Dr. Lopez said that culture is often defined as the “values, beliefs and practices” of a certain group.²⁹ Although this definition has been useful in the past, he noted that it has significant limitations.³⁰ Most importantly, this definition suggests that culture largely resides within peoples’ minds and overlooks the importance of the social world. For example, Latinos are often characterized as being familistic or family-oriented, a value considered to reside within the individual or group. However, this perspective overlooks the fact that the social circumstances of migrating from another country encourage reliance on family members for support. Thus to understand the cultural basis of an individual, family or group, one must examine their social experience and daily routines as well as what they value and believe.

Dr. Lopez offered another definition of culture, one provided by the anthropologist Janice Jenkins and the psychiatrist Marvin Karno: “Culture can be defined as a generalized coherent context of shared symbols and meanings that individuals dynamically create and recreate for themselves in the process of social interaction.”³¹ In addition to recognizing the importance of the social world, this definition also points out that people are not passive recipients of culture. They are actively engaged in sorting through myriad experiences and messages to identify what matters most for them. Thus the cultural background of individuals and groups changes over time contributing to considerable heterogeneity within any particular group. Because of culture’s complex and evolving nature, service providers should inquire about culture on an individual basis to fully understand its role in consumers’ lives.

Dr. Lopez described an approach to understanding culture in a clinical context that was influenced by the anthropological work of Arthur and Joan Kleinman of Harvard University’s Department of Anthropology. The Kleinmans view the ethnographer as one who examines the local context of a

²⁹ Betancourt, H., and Lopez, S. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist* 48: 629-637.

³⁰ Lopez, S., and Guarnaccia, P. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology* 51: 571-598.

³¹ Jenkins, J., and Karno, M. (1992). The meaning of expressed emotion: Theoretical issues raised by cross-cultural research. *American Journal of Psychiatry* 149: 9-21.

behavior and seeks to understand its meaning within that local context.³² In addition the ethnographer examines the behavior through his or her own professional, personal and cultural lenses. From this perspective, mental health decisionmakers can formulate a clearer picture when they can understand the service model within a particular cultural context and then step back and apply their own perspectives on mental illness, mental health and treatment strategies. For example, developing a culturally competent mental health system for Mexican Americans would mean adopting neither a purely Mexican perspective on mental illness and mental health services nor a strictly Anglo-American or mainstream model. A truly culturally appropriate version would involve both perspectives. Dr. Lopez emphasized that the process of moving back and forth between these perspectives for each of the mental health service domains (e.g., engagement, assessment and treatment phases) results in a more culturally competent approach to mental health services.³³

Dr. Lopez illustrated the complexity of culture by sharing an anecdote from his experience driving the highways of Mexico when he was director of a research training program in Mexico City. In Mexico, he noted, truck drivers use turn signals for multiple purposes. By using the left turn signal, a truck driver may indicate that (1) he is about to make a left turn, a symbol used in both the United States and Mexico, or (2) that the road is clear for the trailing driver to pass on the left, a culture-specific symbol in Mexico that is not shared in the United States. Dr. Lopez explained that the trailing driver must entertain both hypotheses to discern the meaning of the turn signal.

Perhaps the driver knows a road is coming up on the left. Perhaps multiple cars have already passed the truck. To understand the true meaning of the turn signal, the driver must consider evidence for both possibilities and not automatically assume the truck signal's purpose. Similarly, in clinical contexts U.S. service providers need to consider both Latino-specific hypotheses as well as hypotheses that they typically use to discern the meaning of given behaviors. Automatically assuming that a particular behavior is "cultural" (a Latino culturally based notion) or "not cultural" (applying one's usual meaning that fails to consider the Latino cultural context) is problematic.³⁴

Finally, Dr. Lopez provided a clinical example to illustrate how using multiple perspectives to view a situation can enhance one's understanding. Julio was born in Mexico and came to the United States at age 14. Because of his cerebral palsy, he was evaluated for disability services, using U.S. norms, and diagnosed as having borderline mental retardation. Dr. Lopez subsequently evaluated Julio at age 21 in both Spanish and English, using tests normed in Puerto Rico and Mexico as well as in the United

³² Kleinman, A., and Kleinman, J. (1991). Suffering and its professional transformations: Toward an ethnography of experience. *Culture, Medicine and Psychiatry* 15: 275-301.

³³ Lopez, S. (1977). Cultural competence in psychotherapy: A guide for clinicians and their supervisors. In C.E. Watkins, Jr., (ed.), *Handbook of Psychotherapy Supervision*. New York: Wiley.

³⁴ Lopez, S. (2000). Teaching culturally informed psychological assessment. In R.H. Dana (ed.), *Handbook of Cross-Cultural/Multicultural Personality Assessment*. Mahwah, NJ: Erlbaum.

States. When applying norms from Puerto Rico and Mexico, Julio was found to be functioning within an average range. However, when using U.S. norms, he was found once again to be functioning within the borderline mental retardation range.

Dr. Lopez posed the question, which was the “right” lens to use with Julio? Based on Latino norms, the young man would not qualify for services offered to those with developmental disabilities, although he had a history of academic difficulties in the United States. It should be noted that the educational background of the standardization sample of the Latino tests was much lower than the standardization samples of the U.S. normed tests. On the other hand, based on the U.S. norms, the young man had a greater chance of qualifying for disability services. However, those norms failed to take into account his limited English proficiency and his sociocultural background, which was quite different from those used in the standardization of the U.S. normed test. Thus each lens provided a limited context to assess Julio’s functioning, in one case in relation to Spanish-speaking Puerto Ricans and Mexicans and in the other case relative to U.S. English-speaking adults. Each one provided an incomplete picture of Julio and his needs.

Considering both perspectives helps the service provider develop a more thoughtful intervention plan, if one is needed. For example, among other needs, Julio would likely have benefitted from additional training in English. This might have been overlooked if he had only been assessed in Spanish (his English language skills would not have been assessed) or in English (his lower functioning may have been attributed to generally low functioning).³⁵ Dr. Lopez emphasized that clinical evaluation and treatment should utilize multiple perspectives carried out in the consumers’ dominant language and in the context of his/her particular background.

Assessment procedures provide clear examples of the use of distinct norms. The use of multiple sets of norms, however, can also be applied to the treatment of mental disorders. One can consider the models that people use to understand their mental health problems and their treatment. Among Latinos, the concept of *nervios* is often associated with distress. This may reflect a syndrome that does not correspond with disorders included in the current Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV) of the American Psychiatric Association or it may be the label that Latinos give to anxiety, depression or even schizophrenic disorders.³⁶ In addition, the explanatory

³⁵ Lopez, S., and Taussig, I. (1991). Cognitive-intellectual functioning of impaired and nonimpaired Spanish-speaking elderly: Implications for culturally sensitive assessment. *Psychological Assessment: Journal of Consulting and Clinical Psychology* 3: 448-454.

³⁶ Guarnaccia P., De La Cancela V., and Carrillo E. (1989). The multiple meanings of ataques de nervios in the Latino community. *Medical Anthropology* 11: 47-62.

Jenkins, J. (1988). Conceptions of schizophrenia as a problem of nerves: A cross-cultural comparison of Mexican-Americans and Anglo-Americans. *Social Science and Medicine* 26: 1233-1243.

Salgado de Snyder, V., Diaz-Perez, M., and Ojeda, V. (in press). The prevalence of nervios and associated symptomatology

models³⁷ that Latinos have for their mental health problems can differ from the models to which U.S. clinicians adhere in their treatment.

To provide culturally responsive therapy for Latino consumers, providers need to become familiar with the world of their patients and their families, particularly the categories they use to describe their mental health problems and their understanding of how these problems developed and can be treated. Doing so will suggest ways that practitioners can integrate the social and cultural context of their Latino patients with their own worlds to provide effective care. According to Dr. Lopez, a wonderful example of tacking between the clinicians' models and Latino families' models is articulated in Celia Falicov's *Latino Families in Therapy: A Guide to Multicultural Practice*.³⁸

Dr. Lopez's presentation illustrated the challenges of providing mental health services that encompass the complexity of cultural competence in comparison with services that adhere to an oversimplified notion of what cultural competence should be. In doing so Dr. Lopez provided an important lens for state mental health agency officials and others in the audience to view the subsequent discussions on disparity and underutilization.

among inhabitants of Mexican rural communities. *Culture Medicine and Psychiatry*.

Liebowitz, M., Salmán, E., Jusino, C., Garfinkel, R., Street, L., et al. (1994). Ataque de nervios and panic disorder. *American Journal of Psychiatry* 151: 871-875.

³⁷ Kleinman, A. (1988). *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: Free Press.

³⁸ Falicov, C. (1998). *Latino Families in Therapy: A Guide to Multicultural Practice*. New York: Guilford Press.

Disparity in Mental Health Services

To launch the discussion on disparity in mental health services, Dr. Sergio Aguilar-Gaxiola presented a definition of disparity used by the National Institute of Mental Health (NIMH) at the National Congress for Hispanic Mental Health funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in March 2000. At the National Congress, NIMH shared that disparity is the difference in the incidence, prevalence, morbidity, mortality and burden of diseases and other adverse conditions that exist among specific population groups.

Dr. Escobar elaborated on the concept of health disparities by explaining how multiple components can intertwine and influence a person's general health. Health outcomes associated with race/ethnicity are affected by the interplay of biological, cultural, socioeconomic, political and legal factors with health practices, psychosocial stress, environmental stress, social mistrust, psychosocial resources and medical care. Given the multidimensional factors that influence health outcomes and disparities, developing a system to address these disparities "defies simple solutions," Dr. Escobar pointed out.

In their efforts to better understand health disparities, researchers need to quantify and measure not only access to and the quality of health care but also differences in disease prevalence, severity and complications. Within general health care, racial and ethnic disparities are monitored by indicators such as infant mortality, immunization rates, breast examinations/mammograms, access to procedures (e.g., heart bypass surgery), diabetes (prevalence and outcomes), hypertension, HIV/AIDS, obesity, chronic heart disease (prevalence and mortality) and strokes (outcomes). Dr. Escobar explained that researchers are able to document these general health care incidences and capture the differences among racial and ethnic groups.

However, Dr. Escobar said that mental health researchers do not yet have objective measures to assess and document disparities in disorder prevalence or treatment adequacy and response on a large scale. Researchers have not developed similar, objective indicators for mental health, making it difficult to quantify disparities in these dimensions. Dr. Escobar proposed the following research areas for further investigation to detect cultural disparities in mental health: prevalence of disorders, diagnostic bias, access to services, quality of services, cultural competency and the cultural advantages associated with certain ethnic and cultural backgrounds.

Dr. Escobar suggested that another indicator of health disparities among racial and ethnic populations is the low numbers of minority physicians and other health professionals, minority

medical school faculty and minority researchers. To illustrate this point, he provided the following racial and ethnic distribution of faculty at U.S. medical schools:³⁹

Culture	Percentage
White	80.6
Asian	10.0
Unknown	3.4
African American	2.8
Other Hispanic	1.9
Puerto Rico	0.8
Mexican American	0.4
Native American	0.1

The lower representation of minority physicians on medical school faculties can also be seen among mental health professionals. Latinos comprised 6.5 percent of psychiatry residents in the United States in 1999-2000.⁴⁰ In a recent national survey of licensed psychologists with an active clinical practice who are members of the American Psychological Association, only 1 percent of the randomly selected sample identified themselves as Hispanic, whereas 96 percent identified themselves as White.⁴¹

After laying this groundwork, panelists addressed specific disparities facing Latinos seeking mental health services.

³⁹ Association of American Medical Colleges. (2000). *Minority Student Opportunities in United States Medical Schools* 15: 3-5.

⁴⁰ American Medical Association. (1999). *Graduate Medical Education Database*. Chicago, IL: American Medical Association.

⁴¹ Williams, S., and Kohout, J. (1999). *A Survey of Licensed Practitioners of Psychology: Activities, Roles and Services*. Washington, DC: American Psychological Association.

Highlights of the Mexico American Prevalence and Services Survey

The Mexico American Prevalence and Services Survey (MAPSS) is a landmark study of the mental health needs of Latinos in California. Dr. Aguilar-Gaxiola and his colleague Dr. William Vega conducted a large-scale study of Mexican Americans in the late 1990's, interviewing more than 4,000 adults in Fresno County, California, a county with a population of 764,810. Researchers conducted in-person interviews with adults ages 18-59, a large number of whom were seasonally employed migrant workers.

The study's main goals were to determine the prevalence rates of fifteen DSM-III-R and DSM-IV mental disorders and patterns of mental health utilization. The five-year, cross-sectional design study allowed researchers to generalize the findings based upon the 4,000 interviews to more than 300,000 people of Mexican origin in the county. Highlights of the MAPSS include the following findings:

- ◆ The most dramatic difference in prevalence rates for mental illnesses appeared to correspond with cultural factors, specifically where the individual was born.
- ◆ Mexican immigrants experienced about one-half the prevalence rates of the major psychiatric disorders of either U.S.-born Mexican Americans or other U.S.-born individuals.
- ◆ Mexican Americans born in the United States had roughly the same rate of mental disorders (48.7%) as the general U.S. population (48.6%).
- ◆ Mexican immigrants to the United States had a similar level of mental disorders (24.9%) as residents of Mexico City (23.4%).⁴²

Time spent in the United States also had an impact on prevalence of mental disorders. Mexican immigrants who have lived in the United States for fewer than 13 years had dramatically lower rates of mental disorders than those who had lived in the United States for 13 years or more, especially alcohol and drug abuse or dependence problems.⁴³

⁴² Vega, W., Kolody B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., and Caraveo-Anduaga, H. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry* 55: 771-778.

⁴³ Vega, W., Alderete, E., Kolody, B., and Aguilar-Gaxiola, S. (2000). Adulthood sequella of heavy drinking among Mexican Americans. *Hispanic Journal of Behavioral Sciences* 22: 254-266.

Dr. Aguilar-Gaxiola also compared prevalence rates for substance abuse and alcohol dependence among Latinos with data from the National Comorbidity Survey (i.e., the national norms). The prevalence rates were as follows:

- ◆ U.S.-born Latinos: 29.3 percent⁴⁴
- ◆ General U.S. population: 28.2 percent⁴⁵
- ◆ Latinos living in Mexico City: 11.8 percent⁴⁶
- ◆ Mexican-born individuals who have lived in the United States for longer than 13 years: 14.3 percent⁴⁷
- ◆ Mexican-born individuals who lived in the United States for fewer than 13 years: 9.7 percent⁴⁸

Panel members pointed out apparent paradoxes revealed by the MAPSS data: being born in Mexico appeared to confer some health advantages. As Dr. Alegria noted, Mexicans and Puerto Ricans generally migrated to the United States with generally better mental health status;⁴⁹ over time, however, they showed increased risk for mental health problems.⁵⁰

In Dr. Vega's study of the 12-month prevalence of mood and addictive disorders in males, rates of depression, dysthymia, mania, alcohol abuse and drug use were far higher for U.S.-born males than for Mexico-born males who immigrated to the United States.⁵¹ Dr. Escobar and his colleagues found similar results in their study of immigrants and U.S.-born persons of Mexican heritage in the Los Angeles area. Rates of major depression found among patients using primary care services were higher among U.S. Whites than among U.S.-born Latinos and Mexican immigrants living in

⁴⁴ Vega et al. (1998).

⁴⁵ Kessler, R., McGonagle, K., Zhao, S., Nelson, D., Hughes, M., Eshleman, S., Wittchen, H., and Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry* 51(1):8-19.

⁴⁶ Vega et al. (1998).

⁴⁷ Vega et al. (2000).

⁴⁸ Vega et al. (2000).

⁴⁹ Vega, W., and Alegria, M. (In press, 2001). Latino mental health and treatment in the United States. In: Aguirre-Molina M., Molina C., and Zambrana R. (eds.), *Health Issues in the Latino Community*. San Francisco, CA: Jossey-Bass Publishers.

⁵⁰ Vega et al. (1998).

⁵¹ Vega et al. (1998).

the United States. Mexican immigrants had lower rates of depression and experienced less melancholia than their U.S.-born White and U.S.-born Latino peers.⁵²

It was noted that similar trends exist for hypertension and heart disease. The Health and Nutrition Evaluation Survey, carried out between 1988 and 1994, comparing hypertension rates among Mexican American men and women found that:⁵³

- ◆ the hypertension rate for individuals born in Mexico was about 15 percent;
- ◆ the rate for U.S.-born, Spanish-speaking individuals was about 30 percent; and
- ◆ the rate for U.S.-born, English-speaking individuals was more than 35 percent.

During a break-out session with Dr. Alegria and Dr. Lopez, participants asked what might account for differences in prevalence rates for mental illnesses between U.S.-born and Mexican-born Latinos. Dr. Alegria proposed the hypothesis that minority status may have an impact on mental health. Individuals who were born in Mexico may have improved mental health (despite experiencing the stressors associated with poverty) because they lived in an area where they were the majority and not exposed to discrimination. The fabric of society, strong family ties and their involvement in the community were advantages that may have compensated for economic disadvantages. Dr. Alegria noted that the effects of community, social supports and stressors such as violence and discrimination are being explored through an NIMH-funded national study on Latinos that is comparable to the National Comorbidity Survey (NCS) directed by Ronald Kessler of Harvard Medical School and the National Study of African Americans by James Jackson, Ph.D., Senior Research Scientist with the African American Mental Health Research Program at the University of Michigan.

Dr. Lopez pointed out that the research of Marcelo Suarez-Orozco, a Harvard University anthropologist, and Carola Suarez-Orozco, a psychologist, in the context of academic achievement may shed some light on a possible factor associated with differences in mental illness rates among Mexican-born and U.S. born Mexican Americans. These researchers found that recent immigrants from Mexico and El Salvador had the same or, in some cases, greater motivation to excel

⁵² Escobar, J., Waitzkin, H., Silver R., Gara, M., and Holman, A. (1998). Abridged somatization: A study in primary care. *Psychosomatic Medicine* 60: 466-72.

⁵³ Sunquist, J., and Winkleby, M. (1999). Cardiovascular risk factors in Mexican-American adults: A transcultural analysis of NHANES III, 1988-1994. *American Journal of Public Health* 89: 723-730.

academically than White or U.S.-born Mexican American students.⁵⁴ More importantly, they noted that the foreign-born Latinos frequently used their family back home as a reference point in assessing their lives in the United States. Given that the social and economic conditions are often much worse in their homeland than in the United States, they may experience less difficulty in handling the stressors of their daily lives than those who lack such a basis of comparison. On the other hand, U.S.-born Latinos are more likely to compare themselves with their peers in the United States. The Suarez-Orozcos argued that these Latino children are more aware of what they do not have and thus may experience more distress. Although reference point has not been considered in studies of mental disorders, it suggests one factor to consider about the intriguing finding of lower prevalence rates among Mexican-born adults than among U.S.-born adults of Mexican heritage.

Another participant asked whether similar trends in prevalence rates would be expected for other immigrant groups. Dr. Alegria responded that comparable results have been found among Chinese Americans, but she cautioned against overgeneralizing this concept. She said that upcoming studies will help to better understand this phenomenon by comparing people living in their original environments with those who have been transposed to a new environment.

MAPSS and other cited studies provided valuable information about prevalence rates and raised important questions that require further study. In addition to prevalence rates, a more complete picture of disparities in mental health includes differences in service utilization rates. The following section addresses MAPSS data on service underutilization.

⁵⁴ Suarez-Orozco, M. (1989). *Central American Refugees and U.S. High Schools: A Psychosocial Study of Motivation and Achievement*. Stanford, CA: Stanford University Press.

Suarez-Orozco, D., and Suarez-Orozco, M. (1995). *Transformations: Immigration, Family Life, and Achievement Motivation Among Latino Adolescents*. Stanford, CA: Stanford University Press.

Latinos' Underutilization of Mental Health Services

Dr. Aguilar-Gaxiola used MAPSS data to address the underutilization of mental health services by Latinos. The data reveal that 32.5 percent of Mexican Americans or other persons of Mexican descent who lived in Fresno County had one or more diagnosable mental disorders. Yet 73 percent of this group received no services for their condition.

The MAPSS data provided additional details about individuals who did obtain mental health services. The utilization pattern was categorized by services received from the following four provider groups:

- ◆ Mental health specialists (psychiatrists, psychologists, social workers, psychiatric nurses, other mental health specialists);
- ◆ General medical (general practitioners, family practitioners, internists, gynecologists, cardiologists, other medical specialties);
- ◆ Other professionals (chiropractors, homeopaths, priests, ministers, rabbis, counselors, nurses); and
- ◆ Informal providers (folk healers, natural healers, spiritualists or mediums, santeros, psychics, astrologists, sobadores).

The study revealed that of survey respondents experiencing one or more mental health disorder in the previous 12 months, only 27.4 percent obtained care from one or more of these sectors:

- ◆ Mental health sector: 8.8 percent
- ◆ General medical sector: 18.4 percent
- ◆ Other professional sector that includes counselors: 12.7 percent
- ◆ Informal provider sector: 3.1 percent

Dr. Aguilar-Gaxiola also elaborated on service barriers revealed by MAPSS for this population of Mexican Americans or those of Mexican descent who lived in Fresno County and who had one or more diagnosable mental disorders:

- ◆ Knowledge: 58 percent reported that they did not know where to obtain help or treatment.
- ◆ Transportation: 19 percent reported they did not have access to transportation to obtain help or treatment.

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- ◆ Proximity to care: 37 percent said they would not consider obtaining mental health services if services were not available near their home.
 - ◆ Language: 50 percent reported that if they sought services, they would prefer speaking in Spanish.⁵⁵

Dr. Aguilar-Gaxiola summed up his overview of MAPSS data by emphasizing that underutilization raises questions of availability, accessibility and appropriateness of mental health care for the Latino population in the United States.

Dr. Escobar also presented data comparing the use of mental health services by the general U.S. population with that of U.S.-born and Mexican-born Latinos living in the United States.⁵⁶ The service utilization data revealed that:

- ◆ 12 percent of the U.S. population used services for mental health problems;
- ◆ U.S.-born Mexican Americans used mental health services at a similar rate (12 %); and
- ◆ slightly more than 4 percent of Mexican-born Mexican Americans used services (about a third of the U.S. national rate).

Dr. Alegria expanded on the reasons for service underutilization by Latinos. She emphasized that a person's ethnicity, socioeconomic status and geographic location have a major impact on identification of need, referral, treatment choice and quality of treatment received. She detailed the disparity in the types of mental health services Latinos received. In an analysis of individuals with psychiatric disorders, persons who are Latino (5.6 %) and African American (6.5 %) were significantly less likely to have received specialty mental health care than non-Latino White persons (11.9 %).⁵⁷ Among Latinos with psychiatric disorders, 7.15 percent were seen in the general health sector and 11.6 percent were seen in the human services sector.⁵⁸

Dr. Alegria pointed out that socioeconomic status played a major role in the type of mental health care a person received. When the National Comorbidity Survey data were analyzed further by poverty status, it was found that low-income Latinos were less likely to receive specialty mental health care than

⁵⁵ Vega et al. (1998).

⁵⁶ Vega et al. (1998).

⁵⁷ Kessler et al. (1994).

⁵⁸ Kessler et al. (1994).

low-income White persons. In addition, African Americans who were not low-income were less likely to receive specialty mental health care than Whites who were not low-income.

Similarly, a geographical analysis of the National Comorbidity Survey data detected geographic variations in access to care. For example, Latinos in the Midwest were less likely than White persons to receive specialty mental health care. Another study examining youth with psychiatric disorders found that young people living in Atlanta, Connecticut and New York had double the mental health treatment rates of youth living in Puerto Rico.⁵⁹

The issue of *where* Latinos access mental health services is an important component of the underutilization discussion. While Latino individuals may exhibit a pattern of underutilization of community-based services, at least one study found that they receive public institutional care at higher rates. A study found that Latinos had a higher rate of admittance to public inpatient facilities and a lower admittance rate to private psychiatric hospitals. The study revealed that White persons were admitted to state and county mental health hospitals at a lower rate than Latino persons (136.8 per 100,000 White persons compared with 146 per 100,000 Latino persons); Latinos had even higher rates of admission to Veterans Affairs (VA) medical centers (64.9 per 100,000 White persons and 227 per 100,000 for Latino persons). The opposite pattern existed for private psychiatric hospitals (63.4 per 100,000 for Whites and 34.4 per 100,000 for Latinos).⁶⁰ This study has implications for both the public mental health system and Latino consumers themselves as both would seemingly be better served by earlier (and less costly) interventions in the community.

Dr. Alegria offered some possible explanations for Latinos' underuse of community-based mental health services. She said that Latinos' under recognition of certain mental health problems may be due to different values systems and a different view of normative behavior. Although Latino youth showed high rates of depressive symptoms, drug use and suicide,⁶¹ there was also lower parental recognition of mental health problems.⁶² In addition, minority families may not view mental health services as beneficial given their other significant daily needs.⁶³

⁵⁹ Leaf, P., Alegria, M., Cohen, P., Goodman, S., and Horwitz, S. (1996). Mental health service use in the community and schools: Results from the four-community MECA study. *Methods for the epidemiology of child and adolescent mental disorders study. Journal of American Academy of Child and Adolescent Psychiatry* 35(7): 889-897.

⁶⁰ Snowden, L., and Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist* 45(3): 347-355.

⁶¹ Roberts, R., Roberts, C., and Chen, Y. (1997). Ethnocultural differences in prevalence of adolescent depression. *American Journal of Community Psychology* 25(1): 95-110.

⁶² Castaneda, D. (1994). A research agenda for Mexican-American adolescent mental health. *Adolescence* 29(113): 225-239.

⁶³ Flores, G., Bauchner, H., Feinstein, A., and Nguyen, U. (1999). The impact of ethnicity, family income and parental education on children's mental health and use of health services. *American Journal of Public Health* 89(7): 1066-1071.

Providers' referral bias may also explain underuse of services. A study by Garland and Besinger found that the rate of court-ordered counseling and psychotherapy differed by ethnicity and race among children in foster care. Latino and African American youth were less likely to be referred for psychotherapy, even when they had the same profile of problems as White youth.⁶⁴ A large proportion of minority children also appeared to receive mental health services through the juvenile justice and welfare systems instead of schools or specialty care settings.⁶⁵

Another contributing factor is that minority individuals appear to experience a higher proportion of misdiagnoses and inappropriate services, which may lead them to perceive treatment as ineffective. One study found that Latino and African American children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) in the public health sector were less likely to receive psychotropic medications than non-Latino White children with ADHD.⁶⁶ Finally, health providers may not understand the psychosocial needs of minority families,⁶⁷ which can lead to culturally inappropriate interventions.⁶⁸

Insurance coverage (or lack thereof) also plays a role in underutilization of services. U.S. Census data from 1999 illustrate that Latinos comprised 35.3 percent of uninsured people compared with non-Latino White persons, who accounted for 11.9 percent of uninsured persons. In addition many Latinos work in jobs that do not offer health insurance benefits such as manual labor and service occupations; others may have a non-citizen status that affects their Medicaid eligibility.⁶⁹

⁶⁴ Garland, A., and Besinger, B. (1997). Racial/ethnic differences in court referred pathways to mental health services for children in foster care. *Children and Youth Services Review* 19(8): 651-666.

⁶⁵ Hough, R., Garland, A., and Reynolds, B. (1995). Race-ethnic differences in the use of mental health services among children in foster care. Presented at the Mental Health Services Research Conference, National Institute of Mental Health, Bethesda, MD.

Close, D., McGowan, M., and Baier, H. (1983). Perspectives on medical records. *Top Health Record Management* 3(4): 1-8.

⁶⁶ Landsverk, J., Leslie, L., Hazen, A., McCabe, K., Yeh, M., and Garland, A. (2000). Cultural influences on use of psychotropic medication for public servicing using youth with a DSM-IV simulated diagnosis of ADHH. Abstract presented at "Challenges for the 21st Century: Mental Health Services Research." Washington, DC: National Institute of Mental Health.

⁶⁷ Finn, P. (1994). Addressing the needs of cultural minorities in drug treatment. *Journal of Substance Abuse Treatment* 11(4): 325-37.

⁶⁸ Guedelman, S. (1983). Developing responsiveness to the health needs of Hispanic children and families. *Social Work Health Care* 8(4): 1-15.

⁶⁹ Meadows, A. (1999). Integrating pharmacy technicians in the health care team. *American Journal of Health Systems Pharmacy* 56(16): 1602-1604.

Medicaid eligibility may increase service utilization as evidenced by the fact that Latino patients who are eligible to receive Medicaid report 42 percent more visits than those who are not Medicaid eligible.⁷⁰ However, a growing number of low-income, Spanish-speaking patients are entering managed care plans that have few interpreters or culturally competent staff with whom to communicate. Latino individuals with fair or poor English proficiency reported about 22 percent fewer physician visits than non-Latinos whose native language is English.⁷¹

Dr. Lopez offered some thoughts on underutilization of mental health and other services based on ethnographic studies of rural Mexican immigrants. Immigrants' understanding of how systems operate is often based on prior experience in their home country. Yet immigrants to the United States often receive little help in understanding how to navigate the complex public and private systems that abound in this country. Thus potential users of public mental health services may "drop out" because of the difficulties and frustration of trying to navigate through this system.

By presenting data on underutilization of public mental health services by persons who are Latino and offering hypotheses, the panelists offered state mental health officials some ideas of how and where to examine their own systems for service barriers.

⁷⁰ Derose, K., and Baker, D. (2000) Limited English proficiency and Latinos' use of physician services. *Medical Care Research Review* 57(1): 76-91.

⁷¹ Derose and Baker. (2000).

National Initiatives To Reduce Health Care Disparities

The long-standing awareness that the playing field is uneven for ethnic and racial minorities seeking mental health services has led to several federal initiatives to place the disparity issue on the national agenda. The *Healthy People 2010* report published by the U.S. Department of Health and Human Services in January 2000 focused attention on the nation's health disparities. One of the report's stated goals was to "eliminate health disparities including those related to gender, race, ethnicity, education, income, disability, living in rural localities and sexual orientation."

Other national initiatives have focused on improving the health and mental health care for Latinos and other ethnic and racial minority populations:

- ◆ National Agenda for Hispanic Mental Health developed at the SAMHSA-sponsored National Congress for Hispanic Mental Health in March 2000.⁷²
- ◆ U.S. Surgeon General's 1999 report on mental health.⁷³
- ◆ 2001 supplement to the Surgeon General's report on mental health, focusing on culture, race and ethnicity.⁷⁴
- ◆ NIMH Research Strategic Plan, which emphasizes investigation into mental health disparities among ethnic minority populations.

Dr. Escobar, a member of the NIMH Council, the advisory body that provides feedback to the director of the Institute, described promising steps taken by the National Institutes of Health (NIH) to address disparity in minority health research. These include:

- ◆ identifying the need to address health disparities as one of the Institute's top seven priorities,
- ◆ creating an NIH special office on health disparities, and

⁷² See <http://www.mentalhealth.org/cmhs/SpecialPopulations/HISpMHCongress2000>.

⁷³ U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

⁷⁴ U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

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- ◆ allocating at least \$60 million for research into health disparities.

Dr. Escobar described the five-part approach adopted by NIH to address this issue: (1) implementing a strategic research agenda encompassing all NIH Institutes; (2) focusing on the recruitment and retention of minority group members; (3) conducting community outreach; (4) building partnerships; and (5) enhancing evaluation/analysis/assessment practices to be more sensitive to the needs of individuals from ethnic, cultural and other minority groups.

Within NIMH, a major focus for improving ethnic and cultural diversity is through education and training at all levels (e.g., high school, undergraduate, pre-doctoral, postdoctoral, new minority faculty and independent research grants). According to Dr. Escobar, NIMH's investment in training of ethnic minorities is the second highest among the Institutes of the National Institutes of Health. In addition, the NIMH Council is examining the education and training continuum to determine where interruptions occur and how the flow of minority candidates can be improved.

According to Dr. Escobar, the best measure of success in expanding the number of minority mental health researchers is to monitor awards for traditional independent research grants (RO1's). Unfortunately, he said, the number of minority investigators who receive RO1's is extremely low. Dr. Escobar believes that "the significant underrepresentation of certain groups among researchers, grant recipients, mentors, grant reviewers, and medical school faculties should be viewed as a critical disparity."

Other specific goals outlined by NIH to address health disparities among different ethnic and racial populations in the United States include achieving a more ethnically and racially diverse pool of mental health investigators and providers, raising awareness in the training and research communities about health disparities; and including significant cohorts of ethnic minorities in clinical studies and trials.

Thus the federal government has responded in many ways to the call for reducing health care disparities through a variety of avenues, particularly in the research arena.

Culturally Competent Service Design

Dr. Martinez, a veteran of the public mental health system and a current vice president of ValueOptions, Inc., a managed care organization that serves more than five million individuals through publicly-funded programs across the nation, outlined his views on the four fundamental elements in systems development needed to achieve culturally competent mental health services:

- ◆ Champion(s) within state mental health agencies, nonprofit organizations, regional and/or county agencies who have the authority, resources and political support to advocate for improved mental health services for Latinos. Dr. Martinez pointed out that the localities on the forefront of Latino mental health issues all have visible champions who have promoted system-change efforts.
- ◆ Standards that are clearly articulated in contracts or relationships between funding agencies and providers, including sanctions for nonperformance. Developing a cultural competence plan is not enough; there must be a strategy and timeline for putting the plan into action. In setting priorities, Dr. Martinez suggested that establishing standards on staffing, access to care and data systems can have the greatest impact on improving the cultural competence of public mental health systems.
- ◆ Latino-focused agencies and services. Although debate continues about whether services for consumers who are Latino should be provided throughout the public mental health system or whether specific agencies should serve specific populations, Dr. Martinez believes that public mental health systems should support minority agencies in the community. For example, he noted that ValueOptions made substantial investments in the infrastructure, staffing and network design of agencies in Maricopa County, Arizona, that primarily serve African Americans, Latinos and Native Americans. The goal is to enhance their capacity to exist and thrive in a competitive managed care environment.
- ◆ School-based services, “where the action is” according to Dr. Martinez. In school, young people, particularly middle school students, begin noticing ethnic and cultural similarities and differences among their peers. As a result of this natural socialization process, some youth experience the differences as too great and begin to disengage from school. This stage provides an important opportunity for collaboration between mental health and school systems to address the mental health needs of a diverse youth population.

Research Informing Service Delivery

A central question concerning the development of culturally competent mental health services is whether new models of practice are necessary to appropriately serve Latino individuals (and other ethnic and cultural populations) or whether modifications in existing mental health services are appropriate. Luis

Zayas, Ph.D., director of the Center for Hispanic Mental Health Research at Fordham University's Graduate School of Social Service, explained that the center is trying to respond to this question by focusing on "research that fits real world circumstances." Dr. Zayas described some of the NIMH-funded Center's activities:

- ◆ development of a measure to examine how Latino elders interpret their psychiatric symptoms and how they seek mental health services. Researchers work in conjunction with three New York agencies that serve Latino elders and hope to determine how to make mental health services and supports more palatable to this population.
- ◆ an effort to reduce depression among late-pregnancy and postpartum Latino and African American women. The study provides mothers with cognitive behavioral interventions in primary care clinical settings, instruction on mobilizing both formal (e.g., hospital, clinic, schools) and informal (e.g., families, church) support, and information on child development.

By partnering with New York City service agencies (and eventually other national partners), the Center for Hispanic Mental Health Research seeks to inform decisionmakers at all levels about what constitutes effective service design for Latino consumers.

State Experiences

During break-out sessions, audience members shared their thoughts and experiences concerning culturally competent mental health service delivery. A New Mexico representative asserted that ongoing, comprehensive training for all individuals involved in the provider system is critical. In addition, this participant said, New Mexico's mental health system has begun to link performance and outcome measures to funding. The state distributes incentive funds based on the regions' success in meeting their outcome goals.

A Connecticut participant described the challenges the public mental health system faces with regard to outreach and peer engagement since Latinos may not have access to the usual points of entry to the public mental health system. Connecticut has supplied additional funding to the provider system both to promote Latino outreach and to support the engagement and retention of Latinos in care for at least the first month.

Connecticut also found that focusing on outcomes leads to better overall mental health care. The state established a multi-phase process to move its public mental health system toward improved outcomes for all clients including members of racial and ethnic minorities. State contracts with mental health providers now include a cultural competence clause, and the state also established an Office of Multicultural Affairs within the Office of the State Mental Health Commissioner, required every provider to have a cultural competence plan and provided technical assistance on developing these plans. In the Spring 2001 contract, the state planned to hold providers accountable for achieving goals established

in these plans. Connecticut is drafting cultural competence standards that eventually will become part of its outcome system. The Connecticut

participant estimated that it takes at least three years to make a significant change in the culture of the provider system.

As with many states, Connecticut's public mental health system has shortages of racially, ethnically and linguistically diverse staff. The state's response to this situation has been to require existing mental health services providers to increase their cultural competence and to expand the number of bilingual providers. The state mental health system identifies areas of Connecticut with high minority populations and offers incentives to providers in these regions to develop a culturally, ethnically and racially diverse staff.

Dr. Lopez suggested another strategy for addressing the shortage of human resources: collaborations between state mental health agencies and universities. For example, Connecticut has established a partnership with the state university system to obtain specialized expertise. When the state has not had funding for such partnerships, state officials approached small liberal arts colleges and offered professors the opportunity to write papers on their unique experiences. A participant from a Miami, Florida, forensic facility mentioned that staff at the facility work closely with the University of Miami and utilize the university's system for training psychiatrists.

A Missouri representative asked whether states with extensive experience in providing culturally competent mental health services for Latino consumers could help states where the Latino population has recently surged. Dr. Lopez surmised that literature from early efforts to attract culturally diverse groups would address the issues currently faced by Missouri and other states. As a rural mental health worker with La Frontera, a mental health agency in Arizona during the mid-1970's, Dr. Lopez witnessed and participated in initial efforts to reach out to Latinos, including visiting housing projects, establishing a telephone warm line, and participating in well baby clinics to inform visitors about postpartum depression and other mental health issues.

Forensic Services

Several participants discussed the difficulties of appropriately serving Latino consumers in the forensic population. In particular, they noted that it is difficult to attract culturally and linguistically competent staff because forensic institutions often are located in rural areas, away from Latino population centers. Washington's state mental health agency has responded to this challenge by developing an extensive, statewide network of interpreters and designating a central agency to certify interpreters and maintain and distribute lists of interpreters. In one instance, the state hired a consultant from Oregon to work with a patient who spoke a certain African dialect.

Population Density and Services

Dr. Alegria hypothesized that ethnic and racial density influences the type and scope of services available to minority populations. She mentioned a Miami study that found high rates of mental health service

utilization among the Latino community, comparable to use by the general U.S. population.⁷⁵ Given the high proportion of Latinos in Miami, Dr. Alegria said that high utilization rates may be due to (1) the community's large and strong network in which someone is always available to help navigate the system and (2) people's positive expectation of services based on their experience in Cuba, where, she said, the mental health system is "very good." Dr. Alegria commented that the density phenomenon has been studied more extensively in the foster care system and needs to be explored further within the public mental health sector.

The group discussed strategies for serving subpopulations such as persons in forensic facilities and the small numbers of some ethnic populations. Participants suggested creating intra- and interstate networks of providers and clinicians to obtain cultural and linguistically competent clinical consultation through teleconferencing. It was noted that telemedicine has been used extensively in South Carolina to provide services for persons with mental illness who are deaf. Using this technology a psychiatrist in one location can consult with practitioners and consumers throughout the state. Hotlines for clinicians and telephone access to forensic evaluators would also help to address the service gaps in many state systems.

Dr. Alegria mentioned another intervention that could be adapted by state mental health agencies for persons who do not speak English. She noted that Stanley D. Rosenberg, Ph.D., a professor of psychiatry at the New Hampshire-Dartmouth Psychiatric Research Center, has translated a short diagnostic battery into several languages on computer for his work with homeless people. The computer responds to touch and sound and helps the clinician obtain diagnostic information. Dr. Alegria urged audience members to be creative and to "push the envelope" in seeking to expand human resources to conduct assessments and provide high-quality mental health care to Latinos.

⁷⁵ Portes, A., Kyle, D., and Eaton, W. (1992). Mental illness and help-seeking behavior among Mariel Cuban and Haitian refugees in South Florida. *Journal of Health and Social Behavior* 33(4): 283-98.

Recommendations

The experts urged decisionmakers to think broadly and boldly when tackling the intransigent issue of cultural disparities within the public mental health system. Drawing on their experience and research findings, several panel members offered policy and service-delivery recommendations for state mental health agency directors to consider.

Dr. Alegria encouraged leaders to adopt culturally competent measures that “move from the politically correct” to strategies that result in “a fair and compassionate system of mental health care for all.” Not only should Medicaid coverage be extended to more Latino families, but policies should be adopted that increase the number of providers who treat minority populations. She urged state mental health agencies to take the following steps:

- ◆ Introduce payment mechanisms that reward increased participation and retention of Latinos in community-based mental health services. Dr. Alegria said that fee-for-service arrangements have a greater negative impact on Latinos’ access to services than capitation-based payments.
- ◆ Create bilingual/bicultural assistance programs that link community mental health centers with schools, churches and community-based organizations to provide mental health interpreters.
- ◆ Develop transitional health insurance programs that address the needs of Latino migrants or temporary workers.
- ◆ Develop clinician support networks to avoid misdiagnosis and provision of inappropriate services. Public mental health officials may assume incorrectly that clinicians are knowledgeable about cultural differences. One strategy for addressing this issue is to create a hotline by which bilingual/bicultural staff can assist other clinicians with assessments.
- ◆ Assess mental health access, treatment and outcomes for Latinos in comparison with White consumers to monitor progress in addressing disparities.
- ◆ Evaluate the factors that account for dramatic geographical differences in availability of specialty mental health services.
- ◆ Initiate a five-year prevention plan in collaboration with the public school system to reduce rates of depression, substance abuse and suicide ideation among Latino adolescents.

Echoing this call to action, Dr. Aguilar-Gaxiola asserted, “There’s no need to keep describing the problem. We need to take action!” He recommended that research findings be translated into clinical applications through a process that involves many constituents. To illustrate the impact that research can have on improving services, Dr. Aguilar-Gaxiola described the community’s eventual use of the MAPSS

results. The researchers initiated community roundtable discussions with stakeholders in Fresno County, which led to the creation of a local Latino Mental Health Task Force consisting of about 30 committed and diverse community leaders representing various disciplines. Dr. Aguilar-Gaxiola said the Task Force used MAPSS and existing county data to help provide guidance to increase access to and enhance the quality of mental health services available to the Latino population in Fresno County through community participation and consensus building. As a result of the Task Force's efforts, for example, the county's Board of Supervisors approved funding for 14 bilingual/bicultural mental health providers.

Other Task Force policy recommendations for creating a culturally and linguistically appropriate service system included:

- ◆ mounting of public education campaigns to create awareness of mental health issues associated with adjustment to American society,
- ◆ dissemination of information on the availability of culturally competent mental health providers and how to gain access to them,
- ◆ making sure that insurance coverage is available for mental health care,
- ◆ providing in-service training for primary health care physicians regarding screening and referral of Latinos who have mental health problems, and
- ◆ implementation and evaluation of cross-cultural competency guidelines.

Although the presenters' list of recommendations was not exhaustive, their strategies illustrate how services research can become a springboard for making mental health systems more responsive to the needs of Latino consumers, their families and other ethnic and racial minorities. Most importantly, the presenters emphasized the need for action, not more discussion, to create culturally competent mental health systems.

Conclusion

In developing this report, NTAC sought to capture some of the energy and can-do spirit evident in the panel discussions on meeting the mental health needs of Latinos at the NASMHPD Commissioners' Meeting, as well as to help identify the challenges that public mental health systems continue to face in providing culturally competent mental health services. The panel exemplified the synergy that can occur when researchers, mental health executives, consumers, providers and policymakers gather to exchange ideas and solve problems.

The panel of experts described the disparities that exist for Latinos and other people of color, particularly in their use of mental health services. The presenters cautioned against simplistic, one-dimensional answers to "fix" the system and make it more accommodating to cultural minorities. Instead, both presenters and participants suggested specific strategies which begin to address the gap in providing culturally and linguistically appropriate mental health services.

Many states are in the early stages of addressing the needs of Latino mental health consumers. Other states with more experience and established programs realize that the process of cultivating cultural competence is ongoing. Regardless of their stage of awareness or program development, state mental health agencies are recognizing the importance of developing culturally competent mental health services.

Model Program:
CONSEJO Counseling and Referral Services
King County, Washington

Overview

Consejo Counseling and Referral Services was established in 1978 as a private, not-for-profit community mental health center serving Latino clients in King County, Washington, which encompasses Seattle and the surrounding vicinity. During the early years, administrators at Consejo, which means “advice” in English, concluded that the agency should offer a broader range of services to meet the needs of its clientele. As a result, the agency has grown to incorporate a variety of mental health, substance abuse and social services focusing on, but not limited to, the Latino community.

Consejo’s clientele includes children, youth, adults and elders, approximately 95 percent of whom are Latino and 80 percent of whom are monolingual Spanish speakers. With multiple locations throughout King County, the program serves an average of 3,800 clients per year, primarily low-income Latino individuals and families living in the greater Seattle area. Consejo also sponsors events that benefit the wider community such as a recent Latino Youth Leadership Conference that drew nearly 600 youth participants from throughout the state.

Culturally Competent Initiatives

The key to Consejo’s success is creating an array of culturally appropriate services for individuals, families and the community. Although the program provides mental health services and supports to persons with serious mental illness, it also provides a range of services to families who are experiencing a variety of social and cultural problems including poverty, immigration issues, cultural adjustment, and limited English-speaking skills. Although the program provides mental health services to persons with serious mental illness, an individual does not need to be diagnosed with a psychiatric disorder to participate in a range of services. Because of its inclusive approach and responsiveness to community needs, Consejo has come to be viewed as an essential and approachable community resource by Latino families in the Seattle area.

Consejo’s spectrum of services includes:

Adult Mental Health Services. The agency provides individual and group therapy, 24-hour on-call case management, psychiatric care, medication management, vocational rehabilitation and housing services for adults with serious and/or persistent mental illness as well as adults experiencing other emotional difficulties.

Child and Family Services. For Latino children and their families experiencing difficulties in behavioral, emotional or social functioning, services include individual and family therapy, 24-hour on-call case

management, psychiatric care and medication management. Consejo offers academic tutoring for students who are having problems in school. It also operates a youth employment program.

School-Based Services. The program employs Latino students to participate in a school-based peer counseling program. Peer counselors, supervised by Consejo staff, are available to talk with other Latino teens about issues and concerns that affect their lives including dating, community and domestic violence, healthy relationships and sexual assault. Consejo's Children's Program also works with youth in schools. The organization's Truancy Program collaborates with the courts, schools, Latino parents and youth to keep young people in school.

Familias Unidas Parenting Program. This 15-week parenting education program for Spanish-speaking families includes a skill-building component in which parents and children socialize on a weekly basis to develop and practice new social skills.

Geriatric Services. For elderly adults (age 60 and older) facing difficulties related to their physical, emotional and/or mental health, Consejo offers support groups, individual therapy, art therapy, recreational activities, home visits, case management, coordination of psychiatric care and psycho-educational services for family members.

Domestic Violence and Sexual Assault Services. For victims of sexual assault or domestic violence, the agency offers a range of services including crisis intervention, community and legal advocacy, individual and group support programs and art therapy. In addition it sponsors a school-based program for victims of teen dating violence, domestic violence and sexual assault or harassment.

Mi Casa Transitional Housing Program. Mi Casa provides a transitional residence for Spanish-speaking women and their children who are recovering from domestic violence. Four families can live in Mi Casa housing for up to three years and obtain case management, support services, parenting education, English-as-a-Second-Language training, individual therapeutic services and employment services.

Perpetrators Treatment. Consejo also provides services including intake, group and individual therapy, and referrals to other needed services for perpetrators of domestic violence. Some participants are referred by the courts while others are self-referred.

Substance Abuse Treatment. Outpatient services including intake and assessment, drug and alcohol information school, intensive outpatient treatment, outreach and education are available to youth and adults with substance abuse problems. The youth substance abuse program combines treatment and prevention, work and recreation, and tutoring and mentoring for Latino Youth.

Las Brisas Transitional Housing Program. Consejo operates supported-living apartments that accommodate 10 adults with histories of homelessness and mental illness. Participants can obtain

services including medication management, case management, vocational rehabilitation, and individual and group therapy.

HIV/AIDS Case Management Program. This program provides case management services along with individual and group support for Latino individuals who have HIV/AIDS.

Family Advocacy Program. To provide support to families that are struggling economically, the agency created a program to assist families in meeting the basic needs of food, shelter, transportation and health care.

Capacidad. Mental health consumers are trained to serve as peer counselors in this pilot program. In addition to offering relevant services, Consejo attracts Latino clients because of its bilingual and bicultural staff, multifaceted presence in the community and other welcoming touches (e.g., playing Spanish music for callers on hold). Indeed, providing culturally competent services has been part of Consejo's identity and mission since day one.

Funding

Consejo receives \$2.6 million annually from a variety of public and private resources, 84 percent of which comes from public grants and contracts (local, state and federal sources) and 16 percent from the United Way and other private sources. State mental health funds account for the largest proportion (61 percent) of the organization's operating budget. Other local and state funding sources include the Seattle city government, King County, the Washington Department of Family Services, the Washington Women's Program and the Washington Council of Prevention of Child Abuse and Neglect. Other funding sources include the U.S. Department of Housing and Urban Development; other federal agencies; and numerous foundations, corporations and other private donors.

Collaborative Efforts

Mario Paredes, Consejo's Deputy Director, expressed the belief that "when we work together, it makes everybody's job easier and results in better services for consumers." Thus Consejo has established partnerships with many other organizations to foster coordinated service delivery, enhance its capacity to provide services, promote closer ties with the community and reduce the geographic and bureaucratic barriers that Latinos might encounter in seeking services.

For example, the King County Department of Public Health provides space in its Bellevue and Federal Way facilities for Consejo to co-locate counselors. Catholic Community Services in Kent has invited Consejo to place an adult mental health therapist at the organization's offices. A number of churches, including Holy Spirit Church, have asked Consejo counselors to work with their parishioners. In addition, Consejo collaborates with area schools, housing programs and other service providers such

as the Harbor View Mental Health Clinic, where consumers who are victims of sexual assault can receive specialized services provided by Consejo.

Evaluation Efforts and Results

Consejo routinely collects and analyzes a variety of outcome data to monitor the effectiveness of its services and provide documentation to current and potential funding sources. In addition, during the past 18 months, the organization has been evaluating itself as part of a strategic planning process that involves surveys of consumers, staff and other stakeholders. Consejo has hired an independent firm to guide the agency through this evaluation process and the development of a three-to-five-year strategic plan. It also conducts annual consumer satisfaction surveys in both Spanish and English.

In recent years, Consejo has received local, state and national recognition for its noteworthy services. In 2001 the organization was selected as a “Champion of Industry” by Pat Summerall Productions and featured on Fox News for its “growth, quality of care and leadership in the behavioral healthcare industry.” Also in 2001, Consejo’s “CAPACIDAD” Peer-to-Peer Natural Support Program received the Innovative Services Award from the King County Mental Health, Chemical Abuse and Dependency Services Division. In 2000 Consejo received the Washington State Exemplary Substance Abuse Prevention Award, and one of the agency’s substance abuse youth counselors received the Direct Service Award from the county’s Mental Health, Chemical Abuse and Dependency Service Division.

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Model Program:
Visiting Nurses Service of New York
New York City

Overview

New York City's Visiting Nurses Service (VNS NY) is among the largest certified home health care agencies in the nation, with a clientele of 22,000 in all five boroughs. The private, not-for-profit agency serves an ethnically-diverse population that includes many Latinos. In addition to traditional home health care services, VNS NY in recent years has expanded the scope of its efforts to encompass a wide range of mental health services including several programs that focus on the mental health needs of Latinos. Among these initiatives are two programs that address the mental health and related needs of young persons and their families in the Bronx's Mott Haven community and the Bronx Geriatric Program.

Youth and Family Programs: VNS NY operates a Mobile Community Support Team and a Respite and Recreation Program through a contract with the Families Reaching In Ever New Directions (F.R.I.E.N.D.S) program, a community-based program funded by the New York State Office of Mental Health and overseen by a board of directors whose members include parents of youth served by the program, other residents of the Mott Haven community, local providers and state and local mental health officials. Established in 1993 with a grant from the federal Center for Mental Health Services's New Initiatives Program, F.R.I.E.N.D.S provides culturally sensitive, family-centered mental health services and supports to a client population that is about 68 percent Latino. Most Latino children and youth served by the VNS NY programs are bilingual. Many come from families in which Spanish is the primary language, and about one quarter have parents who speak only Spanish.

The VNS NY Mobile Community Support Team provides a wide variety of mental health services and supports to youth and their families ranging in duration from a few weeks to several months. The team offers consultation, assessment and crisis intervention services for families and youth, as well as for other service providers working with youth who experience serious emotional distress. The consultation team provides information and advice to parents and service providers and convenes inservice training concerning the needs of seriously emotionally distressed youth for a range of community agencies. The crisis assessment and debriefing team services youth who are at risk of being removed from their homes, schools or the community. A large proportion of these youth are suicidal or assaultive and need immediate help.

In addition, VNS NY operates a Respite and Recreation Program, which offers specialized services for a small group of seriously distressed youth and their families (six youth at a time for a period of six to eight weeks) who are referred from within the F.R.I.E.N.D.S program. The Respite and Recreation Program helps youth who have been unable to function within school-based recreation programs to learn to interact positively with other young people and adults and

works to link them with mainstream recreation programs. In addition, the program provides respite and social activities for the youth and their parents.

Geriatric Program: This program provides both in-home mental health and case management services to adults age 60 and older. A team that includes a psychiatrist, a psychiatric nurse, three bilingual social workers and a case manager provides mental health services to elderly clients, many of them Latinos, experiencing emotional problems ranging from periodic anxiety to serious mental illness. The goal is to help individuals with their immediate mental health and other needs and then to provide linkages to longer term community-based mental health and other services, notes Rebecca Morales, VNS NY Geriatric Program Coordinator. The Geriatric Program has two components, one in the north Bronx, started in 1987, and a second in the south Bronx, which began operation in 1996. Latinos make up more than half of the clients served in the South Bronx and a significant proportion, though not a majority, of those served in the North Bronx.

Culturally Competent Components and Initiatives

Providing culturally competent services that respond to the needs of Latino consumers and their families is a central element of these VNS NY programs:

Youth and Family Programs: Twelve of the 14-member Mobile Community Support Team staff speak Spanish, including the staff psychiatrist, three masters-level social workers, three social work assistants, a full-time administrative assistant and a part-time clerk. In addition the staff includes two parent advocates and two youth advocates, all from the Mott Haven community. Katherine Gordy Levine, M.S.S., director of both programs, emphasizes that the parent and youth advocates play a central role in the programs, contributing greatly to community outreach efforts and helping to ensure that other staff members understand and respond to the needs of consumers and their families. Of the Respite and Recreation Program's five-person staff, four speak Spanish including three respite workers and the administrative assistant. Program staff make a concerted effort to reach out to the residents of the Mott Haven community and to overcome language and cultural barriers. Spanish-speaking staff members answer telephones so that callers feel welcome and can communicate in Spanish if they wish to do so. Staff members also participate in a wide range of community outreach activities that include convening support group meetings at neighborhood schools, taking part in community events such as picnics and celebrations and leading outings for youth and their families.

In recognition of the important role played by the extended family and the community in Latino culture, VNS NY staff encourage the development of a team approach to addressing the needs of each youth and family it serves. In addition to the young person who receives services, team members may include parents or other primary care givers and siblings; other relatives and friends; and the professionals involved in the young person's care such as doctors, teachers and attorneys. Together they seek to identify mental health issues and other problems the young person is experiencing and to develop a collaborative plan to address these concerns.



Other culturally competent aspects of the program include:

- ◆ Consumer progress notes developed jointly by the clinician, the youth and, depending on the young person's age, his or her parents or guardians. These notes establish service and outcome goals for the young person and provide regular assessments of progress from each participant's perspective. Progress notes are kept in both Spanish and English, and copies are provided to consumers and their families. In addition youth and their parents or other primary care givers complete a brief consumer satisfaction rating questionnaire following each session of therapy. The questionnaire, which is provided in both Spanish and English, asks consumers and their parents to rate the session's effectiveness in several areas. "Often everything is fine, but sometimes the therapist or case manager will receive feedback identifying a problem," Ms. Levine said. "We have to make sure the consumer and family voices are heard."
- ◆ Participation by program staff in cultural competency training programs that include in-house activities as well as conferences, meetings and workshops at educational and medical institutions throughout New York City. VNS NY operates its own "Community Mental Health University," which provides new staff members with information about community mental health services, including cultural competence issues. Activities include programs on stigma and mental illness as well as Spanish-language instruction.
- ◆ One special feature of the program is the Camino de Paz Labyrinth Project. Ms. Levine came upon the idea for the labyrinth during a visit to a Quaker meeting sponsored labyrinth in Purchase, New York. "I walked the labyrinth and observed that this would be a wonderful experience for our kids," she recalls. The Camino de Paz, which means road of peace in Spanish, provides an opportunity for quiet reflection and meditation amid the bustle of the busy urban neighborhood, she says. There are now four labyrinths in Mott Haven, all sponsored by the Camino de Paz Labyrinth Project. Youth in the program have created two portable labyrinths to take to street fairs and other community events. Youth and VNS NY staff members have also painted labyrinths at an abandoned basketball court and on a church playground. Program staff also hope to construct a permanent Camino de Paz labyrinth at a neighborhood park. Ms. Levine notes that many cultures and religions have used labyrinths for both meditation and religious observation and that the project has created an opportunity to discuss how similar themes often appear in diverse cultures.

Geriatric Program: In addition to having a high proportion of staff members who are fluent in Spanish, the program provides staff members with opportunities to participate in a variety of training activities such as a recent five-day course on cultural competency at Hunter College. Staff become well versed in issues that may have special relevance for older Latino individuals, such as the importance of involving their adult children and other members of their extended family in the planning and provision of services. Because many elderly Latino clients speak only Spanish, program staff often assist them to bridge the language gap in their interactions with public and private health and social services agencies. In many

cases, however, program staff find it difficult to link elderly Latino clients with culturally competent geriatric programs or mental health providers, so they continue their involvement until appropriate, long-term services are found.

Staff also learn to distinguish between beliefs and perceptions that may have a spiritual or cultural basis and those that could signify mental illness. In addition, program staff are aware of the taboos and stigma concerning mental illness that exist within the Latino community, especially among older clients, who may prefer the term “problem with nerves” to a clinical diagnosis. All outreach materials, including brochures, flyers and posters, are available in both Spanish and English.

Funding

Youth and Family Programs: The Visiting Nurses Service of New York receives annual funding of about \$300,000 to operate these two programs from the New York State Office of Mental Health through a contract with the F.R.I.E.N.D.S program.

Geriatric Program: This program receives \$412,000 annually from the New York City Department of Mental Health, Mental Retardation and Alcoholism Services.

Collaborative Efforts

Children and Family Programs: Program staff collaborate with many other community-based organizations and individuals including the F.R.I.E.N.D.S program staff, community mental health centers and other community health agencies, churches, recreation centers, members of the city-appointed community board, the Mott Haven Agenda for Children Tomorrow child welfare initiative, and law enforcement officials. There are plans to partner with a 12-step program to provide alcohol and drug abuse services to youth participants and family members. Program staff also provide consultation to area schools, teachers, parents and others on providing culturally appropriate mental health services to Latino youth and their families.

Geriatric Program: Staff collaborate with a wide range of community organizations including community mental health centers, churches, neighborhood groups, hospitals and other health facilities. The Regional Aid for Interim Needs (RAIN) program, a New York City Department of Aging program that provides services to clients in a number of areas including mental health, also collaborates with the VNS NY Geriatric Program. Referrals come from a variety of sources including VNS NY home care staff, doctors and nurses, family members, neighbors and elderly individuals themselves.

Evaluation Efforts and Results

Children and Family Programs: More than 95 percent of youth and their parents or other primary care givers involved in the Mobile Community Support Team or Respite and Recreation programs have provided positive evaluations both on the progress notes and on individual session rating scales. [See “Culturally Competent Components and Initiatives” above for more information on these evaluation activities.]

Geriatric Program: Program staff elicit client comments on the quality of services through a patient satisfaction survey conducted at the close of each intervention.

Contact Information

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Geriatric Program

Rebecca Morales, M.S.W.

Project Coordinator

1601 Bronxdale Avenue

Bronx, NY 10462-3701

(718) 319-7329

email: lsacco@vnsny.org

Suggested Readings on Cultural Competency

Cultural Diversity Series (current volumes):

National Technical Assistance Center for State Mental Health Planning. (1998). *Cultural Diversity Series: Meeting the Mental Health Needs of African Americans*. Alexandria, VA: Author.

McCarn, S.R. (1999). *Cultural Diversity Series: Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

National Technical Assistance Center for State Mental Health Planning. (2000). *Examples from the Field: Programmatic Efforts To Improve Cultural Competence in Mental Health Services*. Alexandria, VA: Author.

Cultural Diversity Series (volumes in development):

Meeting the Mental Health Needs of American Indians and Native Alaskans.

Meeting the Mental Health Needs of Asian and Pacific Islander Americans.

Meeting the Mental Health Needs of Persons Who Are Deaf.

Other Suggested Readings:

American Counseling Association. *Journal of Multicultural Counseling and Development*.

Arredondo, P., Toporek, R., and Brown, S., et al. (1996). *Operationalization of Multicultural Counseling Competencies*. Alexandria, VA: Association of Multicultural Counseling and Development.

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Atkinson, D., Morten, G., and Sue, D. (1998). *Counseling American Minorities: A Cross-Cultural Perspective, 5th Edition*. New York, NY: McGraw-Hill.

Bernal, G. Bonilla, J., and Belido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology* 23: 67-82.

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Center for Mental Health Services, Refugee Mental Health Branch. (1994). *Lessons Learned from Regional Workgroup Meetings on Programs for Vietnamese Former Political Prisoners*. Rockville, MD: Author.

Daugherty, D. and Stanhope, V. (Eds.) (1998). *Pathways to Tolerance: Student Diversity*. Bethesda, MD: National Association of School Psychologists.

Davis, K. (1997). *Exploring the Intersection Between Cultural Competency and Managed Behavioral Health Care: Implications for State and County Mental Health Agencies*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Droby, R. M. (2000). *With the Wind and the Waves: A Guide for Non-Native Mental Health Professionals Working Within Alaska Native Communities*. Nome, AK: Norton Sound Health Corporation.

Escobar, J., Hoyos-Nervi, C., and Gara, M. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry* 8: 64-72.

Gaw, A. (Ed.). (1993). *Culture, Ethnicity and Mental Illness*. Washington, DC: American Psychiatric Press.

Gay, Lesbian, Bisexual and Transgender Health Access Project. (1999). *Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients*. Boston, MA: Massachusetts Department of Mental Health.

Isaacs, M., and Benjamin, M. (1991). *Towards a Culturally Competent System of Care: Volume II*. Washington, DC: Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Isaacs, M., and Benjamin, M. (1998). *Towards a Culturally Competent System of Care: Volume III*. Washington, DC: Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Isaacs Shockley, M. (1997). *State of the States: Responses to Cultural Competence and Diversity in Child Mental Health*. Washington, DC: National Technical Assistance Center for Children's Mental Health.



Lee, E. (Ed.) (1997). *Working With Asian Americans: A Guide for Clinicians*. New York: Guilford Press.

Lee, L.C. and Zane, N.W.S. (Eds.) (1998). *Handbook of Asian American Psychology*. Thousand Oaks, CA: Sage Publications.

Lopez, S., and Hernandez, P. (1986). How culture is considered in the evaluation of mental health patients. *Journal of Nervous and Mental Disease* 174: 598-606.

Lynch, E., and Hanson, M. (1998). *Developing Cross-Cultural Competence: A Guide for Working with Children and Their Families*. Baltimore, MD: Paul H. Brookes Publishing Co.

Miller, C., Peck, L., Shuman, J., and Yrn-Calenti, C. (1995). *Building Bridges: Tools for Developing an Organization's Cultural Competence*. Tucson, AZ: La Frontera.

Munoz, R., and Sanchez, M. (1997). *Developing Culturally Competent Systems of Care for State Mental Health Services*. Boulder, CO: Western Interstate Commission for Higher Education.

New York State Office of Mental Health. (1998). *Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs*. Albany, NY: Author.

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Ohio Department of Mental Health Office of Consumer Services, Outcomes Management Group, Ltd., and Innovative Consultants International, Inc. (1998). *Cultural Competence in Mental Health: A Study of Nine Mental Health Programs in Ohio*. Columbus, OH: State Printing.

Phillips, D., Leff, H., Kaniasty, E., Carter, M., Paret, M., Conley, T. and Manisha, S. (1999). *Culture, Race and Ethnicity (c/r/e) in Performance Measurement: A Compendium of Resources*. Cambridge, MA: The Evaluation Center @HSRI.

Ponterotto, J. (1995). *Handbook of Multicultural Counseling*. Thousand Oaks, CA: Sage Publications.

Ponterotto, J., and Pedersen, P. (1993). *Preventing Prejudice: A Guide for Counselors and Educators (Multi-Cultural Aspects of Counseling, Vol. 2)*. Thousand Oaks, CA: Sage Publications.

Roizner, M. (1996). *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations*. Boston, MA: Judge Baker Children's Center, Technical Assistance Center for the Evaluation of Children's Mental Health Systems.

Ryan, C. and Futterman, D. (1998). *Lesbian and Gay Youth: Care and Counseling*. New York: Columbia University Press.

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2000). *Creating a Vision for the 21st Century: Proceedings of the National Congress for Hispanic Mental Health*. Rockville, MD: Author.

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Sue, S. (1983). *The Mental Health of Asian Americans*. San Francisco, CA: Jossey-Bass Publishers.

Sue, S., Fujino, D., Hu, L., and Takeuchi, D. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology* 59:533-540.

Transgender Education Network. (1998). *Determining Barriers to Treatment for Transsexuals and Transgenders in Substance Abuse Programs*. Boston: JRI Health.

Uba, L. (1994). *Asian Americans: Personality Patterns, Identity, and Mental Health*. New York: The Guilford Press.

U.S. Department of Health and Human Services (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Vera, M., Alegria, M., Freeman, D., Robles R., Pescosolido, B., and Pena, M. (1998). Help seeking for mental health care among poor Puerto Ricans: Problem recognition, service use, and type of provider. *Medical Care* 36(7): 1047-1056.

White, J., and Parham, T. (1990). *The Psychology of Blacks: An African American Perspective*. Upper Saddle River, NJ: Prentice Hall.

Organizational Resources

Action Council for Cross-Cultural Mental Health and Human Services, Inc.

The Action Council
P.O. Box 1695
Columbia, SC 29202
(803) 898-8619
Fax: (803) 898-8624
Contact: Dolores Macey

The Action Council for Cross-Cultural Mental Health and Human Services, Inc. is a voluntary organization dedicated to enhancing the involvement of minority citizens in the management, delivery and utilization of mental health and human services. A dues-collecting, membership organization, the Action Council provides programmatic and policy consultation and training for managers and decisionmakers, and promotes education in understanding diverse cultures. The Action Council sponsors an annual conference in conjunction with the South Carolina Department of Mental Health and other organizations.

African American Family Services

2616 Nicollet Avenue South
Minneapolis, MN 55408
(612) 871-7878
Fax: (612) 871-2567
www.aafs.net
Contact: Tasselean Parker

The mission of African American Family Services is to help the African American individual, family and community reach a greater sense of well-being through the delivery of community-based, culturally specific chemical health, mental health, and family preservation services.

AIDS Mental Health Training Program

UCLA Center for Health Promotion and Disease Prevention
Center for Health Sciences, Room 61-236
10833 LeConte Avenue, Box 951772
Los Angeles, CA 90095-1772
(310) 794-7130
Fax: (310) 206-5717
www.medsch.ucla.edu/aidsinst/education/edprograms/index.html
Contact: Thomas Donohoe

The Center for Mental Health Services-funded AIDS Mental Health Training Program (AMHTP) at UCLA offers HIV knowledge- and skill-based training tailored to mental health providers and health educators who work with people with serious mental illness. AMHTP training programs provide extensive information about HIV and AIDS, as well as experiential training to practice prevention and intervention skills. AMHTP trainings are provided in English and Spanish, and address the unique challenges of communicating about and treating HIV-related concerns among mental health service consumers.

American Counseling Association

Association for Multicultural Counseling and Development (AMCD)

P.O. Box 2256

Sacramento, CA 95812-2256

(916) 424-8959

Fax: (916) 424-3985

Contact: Dr. Marcelett Henry

Established in 1972 under the American Counseling Association, the AMCD works to develop an efficient and effective system of organizational management, enhance existing professional standards and promote and expand culturally competent research and knowledge.

American Psychiatric Association (APA)

Committee on Gay, Lesbian and Bisexual Issues

1400 K Street, NW

Washington, DC 20005

(202) 682-6097

Fax: (202) 682-6837

Contact: Janice Taylor

The APA Committee on Gay, Lesbian and Bisexual Issues is charged to investigate problems and issues which affect the mental health of the gay, lesbian and bisexual populations, such as discrimination and stigmatization; develop teaching programs to help correct the inadequate training of psychiatrists about homosexual issues; and promote the education of the APA membership and the general public about homosexuality.

American Psychological Association (APA)

Division 44

Society for the Psychological Study of Lesbian, Gay and Bisexual Issues

729 Boylston Street, 4th Floor

Boston, MA 02116

(617) 262-0315

www.apa.org/about/division/div44.html

Contact: Douglas M. Deville, Psy.D.

The APA Division 44, addressing gay, lesbian and bisexual concerns, focuses on the diversity of human sexual orientations by supporting research, promoting relevant education, and addressing professional and public policy. It has committees and task forces on accreditation, bisexuality, education, public policy, youth and families, ethnic/racial diversity issues, and science and research. Division 44 publishes a newsletter three times a year and a program describing Division 44's activities for distribution at the annual APA convention.

American Psychological Association (APA)

Office of Ethnic Minority Affairs

750 First Street, NE

Washington, DC 20002-4242

(202) 336-5500

Fax: (202) 336-6040

www.apa.org/pi/oema/

Contact: Alberto Figueroa

The APA Office of Ethnic Minority Affairs (OEMA) seeks to promote scientific understanding of the influences of culture and ethnicity on behavior, encourage increased public knowledge of the special psychological resources and mental health needs of communities of color, and increase the number and participation of ethnic minority psychologists in the discipline and the Association. In support of these objectives, OEMA's activities include maintaining and editing the *Directory of Ethnic Minority Professionals in Psychology*, operating a minority job bank and publishing *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*.

Asian and Pacific Islander American Health Forum

942 Market Street, Suite 200

San Francisco, CA 94102

(415) 954-9955

Fax: (415) 944-9999

www.apiahf.org

Contact: Tessie Guillermo

Washington, DC Area:

440 First St. NW, Suite 430

Washington, DC 20001

(202) 624-0007

Fax: (202) 624-9488

A national advocacy, policy and research organization dedicated to improving the health of Asian and Pacific Islander Americans. The Health Forum offers publications and fact sheets on all aspects of Asian and Pacific Islander health including mental health. The Forum also maintains a closed and moderated mailing list as an information and referral point for individuals and organizations that provide alcohol, substance abuse and mental health services.

Association of Asian Pacific Community Health Organizations (AAPCHO)

439 23rd Street

Oakland, CA 94612

(510) 272-9536

Fax: (510) 272-0817

www.aapcho.org

Contact: Jeffery B. Caballero, M.P.H.

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national association representing community health organizations dedicated to promoting advocacy, collaboration and leadership that improves the health status and access of Asian Americans, Native Hawaiians and Pacific Islanders within the United States, its territories and freely associated states, primarily through member community health clinics. Formed in 1987, AAPCHO advocates for policies and programs that will improve the provision of health care services that are community driven, financially affordable, linguistically accessible, and culturally appropriate. As a unified voice of its membership, AAPCHO shares its collective knowledge and experiences with policy makers at the national, state and local levels.

Center for Hispanic Mental Health Research

Graduate School of Social Service

Fordham University

113 West 60th Street

New York, NY 10023-7484

(212) 636-7085

Fax: (212) 636-7079

Contact Luis Zayas, Ph.D., Director

Established in 1999 with a grant from the National Institute of Mental Health, the Center for Hispanic Mental Health Research at Fordham University's Graduate School of Social Service conducts applied research focusing on Hispanic populations to generate new knowledge leading to improved mental health services for this growing segment of the U.S. population. Among the center's primary objectives are to conduct epidemiological research identifying the mental health needs of diverse Hispanic groups; conduct studies into ways that standard assessment, treatment and prevention strategies can be modified to enhance mental health outcomes for Hispanics; conduct psychotherapeutic intervention studies that test the efficacy and effectiveness of new culturally competent psychosocial services; and disseminate information about research findings through a variety of publications and other forums. In addition the center is dedicated to increasing the number of researchers, both faculty and students, in the field of mental health. The center's research activities focus on mental health issues that particularly affect Hispanics in the northeastern United States but that also have implications for Hispanic and Latino populations throughout the nation.

**Gay, Lesbian, Bisexual and Transgender
Health Access Project**

Justice Research Institute Health
100 Boylston Street, Suite # 815
Boston, MA 02116
(617) 988-2605
Fax: (617) 988-8708
www.glbthealth.org
Contact: Mary Clark, Director

The Gay, Lesbian, Bisexual and Transgender (GLBT) Health Access Project, in partnership with the Massachusetts Department of Public Health, works to foster the development of comprehensive, culturally appropriate health promotion policies and health care services for gay, lesbian, bisexual and transgender people through a variety of venues including community education, policy development, advocacy, direct service and prevention programs. GLBT Health Access recently published “Community Standards of Practice for the Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgender Clients.” These Community Standards offer detailed guidelines for making health and mental health services accessible and culturally appropriate for GLBT persons. Training and technical assistance regarding the use of these guidelines is now being provided to service settings throughout Massachusetts through the Fenway Community Health Center.

**Georgetown University Child Development Center
National Technical Assistance Center for Children’s Mental Health**

3307 M Street, NW, Suite 401
Washington, DC 20007
(202) 687-5000
Fax: (202) 687-1954
www.gucdc.georgetown.edu

The mission of the Georgetown University Child Development Center is to improve the quality of life for children with special needs and their families. Products and services include information packets, issue briefs and monographs on children and adolescents with serious emotional disturbances; conferences and training institutes on planning, delivery and financing of services and on increasing cultural competence in mental health service delivery; consultation on systems change and services development and delivery; and agency and organizational collaboration.

**Multi-Ethnic Behavioral Health Resource
and Training Center**

17 S. High Street, Suite 500
Columbus, OH 43215
(614) 228-2220
Fax: (614) 228-2285
www.mebhc.com
Contact: Marty Miller

The Training Center provides advocacy and training on cultural diversity and mental health issues relevant to the needs of African American, Asian, Hispanic and Native American residents of Ohio.

National Alliance for Hispanic Health

1501 16th Street, NW
Washington, DC 20036
(202) 387-5000
Fax: (202) 265-8027
www.hispanichealth.org
Contact: Jane Delgado, President

The National Alliance for Hispanic health is the oldest and largest network of health and human service providers servicing over 10 million Hispanic consumers throughout the U.S. Since 1973 the National Alliance for Hispanic Health has grown from a small coalition of visionary mental health providers to a large, dynamic, and strong group of organizations and individuals whose mission is to inform and mobilize consumers; support health and human service providers in the delivery of quality care; improve the science base for accurate decision making; promote appropriate use of technology; and insure accountability and advocate on behalf of Hispanics.

**National Asian American and Pacific Islander
Mental Health Association**

565 South High Street
Denver, CO 80209
(303) 765-5330
Fax: (720) 223-2381
www.NAAPIMHA.org
Contact: D.J. Ida, Ph.D.

The National Asian American and Pacific Islander Mental Health Association's (NAAPIMHA) mission is to promote the mental health and well being of Asian Americans and Pacific Islanders. NAAPIMHA advocates on behalf of AAPI mental health issues as well as serves as a forum for effective collaboration and networking between stakeholders of community based organizations, consumers, family members,

service providers, program developers, evaluators and policy makers representing the various ethnic and regional differences. NAAPIMHA focuses on the following areas, recognizing that cultural competency will be reflected at all levels: (1) enhance collection of appropriate and accurate data; (2) identify current best practices and service models; (3) increase capacity building which includes providing technical assistance and training of service providers, both profession and para-professional; (4) conduct research and evaluation; and (5) work to engage consumers and families.

National Asian Pacific American Families

Against Substance Abuse

340 East Second Street, Suite 409

Los Angeles, CA 90012

(213) 625-5795

Fax: (213) 625-5796

www.napafasa.org

National Asian Pacific American Families Against Substance Abuse (NAPAFASA) is a private, non-profit, 501(c)(3) membership organization dedicated to addressing mental health and substance abuse concerns of Asian and Pacific Islander (API) populations on the continental U.S., Hawaii, the six Pacific Island jurisdictions and elsewhere. Founded in 1988, NAPAFASA involves service providers, families, and youth in efforts to reach API communities to promote health, social justice and reduce substance abuse and related problems.

National Association of Social Workers (NASW)

National Committee on Lesbian, Gay

and Bisexual Issues (NCLGB)

750 First Street, NE, Suite 700

Washington, DC 20002-4241

(202) 408-8600

Fax: (202) 336-8310

www.socialworkers.org

Contact: Evelyn P. Tomaszewski, ACSW

NCLGB works to promote the development of knowledge, theory and practice as related to gay, lesbian and bisexual issues; to identify ways to eliminate homophobic social work practices and policies (e.g., so-called reparative therapies); and to assist the association and the larger profession in developing lesbian, gay and bisexual affirming policies, procedures, and programs. NASW supports curriculum content that affirms lesbian, gay, and bisexual people; encourages implementation of relevant continuing education; strives for full representation of lesbian, gay, and bisexual people at all levels of leadership and employment in social work; and advocates for and encourages efforts to end violence and discrimination towards gay, lesbian, and bisexual people.



**National Center for American Indian and
Alaskan Native Mental Health Research**

University of Colorado Health Sciences Center
Department of Psychiatry
4455 East Twelfth Avenue
Campus Box A011-13
Denver, CO 80220
(303) 315-9232
Fax: (303) 315-9579
www.uchsc.edu/sm/ai/ncaianmhr/
Contact: Spero Manson, Ph.D., Director

Funded by the National Institute of Mental Health, the National Center for American Indian and Alaskan Native Mental Health Research focuses on research, research training, information dissemination and technical assistance for American Indian and Alaskan Native populations. The Center has developed a computerized bibliography on Indian and Alaskan Native mental health and a resource directory that inventories individuals, programs and agencies with expertise in mental health research, service and education specific to Indian and Alaskan Native communities.

National Council of La Raza (La Raza)

111-19th Street, NW, Suite 1000
Washington, DC 20036
(202) 785-1670
Fax: (202) 776-1792
www.nclr.org
Contact: Helen Coronado

La Raza is a private, nonprofit organization established in 1968 to reduce poverty and discrimination and improve opportunities for Hispanic Americans. La Raza works toward this goal primarily through capacity-building assistance to support and strengthen Hispanic community-based organizations; promoting applied research, policy analysis and advocacy to provide a Hispanic perspective on issues such as education, housing, and health; and encouraging the adoption of programs and policies that equitably serve Hispanics.

National Latino Behavioral Health Association (NLBHA)

P.O. Box 387
Berthoud, CO 80513
(970) 532-7210
Fax: (970) 532-7209
Contact: Marie Sanchez, B.S.W.

The roots for the National Latino Behavioral Health Association began on March 2000 as over 100 key Hispanic community leaders and key partners met at a historical National Congress for Hispanic Mental Health convened by the Substance Abuse and Mental Health Services Administration (SAMHSA). A national agenda and an action plan to improve mental health services for the Latino community were crafted at the Congress. As part of its mission, NLBHA will use the agenda and action plan as guideposts in improving the mental health and substance abuse needs of the Latino population.

National MultiCultural Institute (NMCI)

3000 Connecticut Avenue, NW, Suite 438

Washington, DC 20008-2556

(202) 483-0700

Fax: (202) 483-5233

www.nmci.org

Contact: Elizabeth P. Salett

A non-profit organization located in Washington, D.C., NMCI offers organizational consulting and training—including diversity training and organizational development initiatives—sponsors multicultural conferences, produces educational resource materials and provides multicultural counseling and referral services.

National Research Center on Asian American Mental Health

Department of Psychology—University of California at Davis

One Shields Avenue

Davis, CA 95616-8686

(530) 752-1400

Fax: (530) 752-3747

<http://psychology.ucdavis.edu/asianamerican/>

Contact: Stanley Sue, Ph.D.; Nolan Zane, Ph.D.

The National Research Center on Asian American Mental Health (NRCAAMH) was established in 1988 with a grant from the National Institute of Mental Health. NRCAAMH prides itself as a national and multidisciplinary leader in the study of Asian American and Pacific Islander mental health research. NRCAAMH was founded out of a need for programmatic research devoted to address mental health concerns. The Center aims to contribute theoretical and applied research that will have impact on mental health policy and service delivery to Asian Americans and Pacific Islanders.

Office of Minority Health Resource Center

P.O. Box 37337

Washington, DC 20013-7337

(800) 444-6472

Fax: (301) 230-7198

TTY: (301) 230-7199

www.omhrc.gov/omhrc/index.htm

Contact: Jose Tarcisio M. Carneiro, M.P.A., Ed.D.

The Minority Health Resource Center is a national resource and referral service for minority health issues that provides information on funding sources and community programs. The Center's newsletter, "Closing the Gap," is available free of charge. A customized data base searches health resources for African Americans, Asian Americans, Pacific Islanders, Latinos, and Native American populations.

The Program for Research on Black Americans

5062 Institute for Social Research

P.O. Box 1248

Ann Arbor, MI 48106-1248

(734) 763-0045

Fax: (734) 763-0044

www.isr.umich.edu/rcgd/prba

Contact: Susan Frazier-Kouassi, Ph..D.

The Program for Research on Black Americans (PRBA), historically characterized by its vision and innovation, has undertaken a number of important studies focusing on the mental health of African Americans. In 1998, PRBA received funding from the National Institute of Mental Health to create the African American Mental Health Research Program (AAMHRP). The overall objectives of AAMHRP are to introduce a new period of growth and implement a consolidation of the intellectual, scholarly, research, and training capabilities of the PRBA in studying mental health problems and serious mental disorders among African American populations.

TransGender Education Network

JRI Health, TEN

100 Boylston Street, Suite 860

Boston, MA 02116

(617) 988-2605, ext. 211

Fax: (617) 988-2629

www.jri.org/ten.html

Contact: Daviko Marcel, Program Director

TEN is an HIV prevention and health promotion initiative aimed at Greater Boston's transgender community. The project works in three ways: by providing education for medical and human service providers outlining the health and social service needs of transgendered persons; community-building events for the transgender community to foster self-esteem and an awareness of each person's right to medically and culturally appropriate health and social services; and outreach which links transgendered persons to the services and resources they need.

**Western Interstate Commission on
Higher Education (WICHE)
Mental Health Program**

P.O. Box 9752

Boulder, CO 80301-9752

(303) 541-0250

www.wiche.edu/mentalhealth/

Contact: Jim Stockdill, Ph..D.

WICHE is a public interstate agency established to promote and facilitate resource sharing, collaboration and cooperative planning among the western states for higher education and work force needs. Member and affiliate states include Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming. WICHE has been involved, through contracts with SAMHSA, in key national efforts to improve cultural competence in mental health care services, and was instrumental in efforts to generate standards of care for culturally competent mental health care service provision to members of underserved/underrepresented racial ethnic groups.

Appendices

Appendix A:

NASMHPD Position Statement on
Culturally Competent and Linguistically Appropriate
Mental Health Services

**POSITION STATEMENT ON
CULTURALLY COMPETENT AND LINGUISTICALLY APPROPRIATE
MENTAL HEALTH SERVICES**

The National Association of State Mental Health Program Directors (NASMHPD) recognizes that state mental health agencies face a growing challenge to accommodate an increasingly diverse constituency for mental health services nationwide. The provision of culturally and linguistically appropriate and accessible mental health services regardless of race, gender, age, disability, sexual orientation, national origin, language, religion or socioeconomic status challenges state mental health agencies to develop, expand, and evaluate effective, culturally competent services and treatment methods.

As the U.S. population changes dramatically, so does the mental health system consumer base. Public mental health systems and staff may be unprepared for differences in language, cultural perspective, traditions, perceptions about mental illness and preferences for services and supports. For example, more than 1 in 4 Americans are non-white and/or Latino, but by the year 2050, the U.S. Census Bureau projects that nearly 1 in 2 Americans will be so. New and changing cultural perspectives, emerging cultural groups, and the growing realization that cultural identity contributes in essential ways to mental well-being require new attention to the need for culturally appropriate mental health services.

Members of ethnic, racial, linguistic, and culturally diverse groups are often underserved or inappropriately served by the public mental health system. Culturally competent and appropriate services can: reduce inappropriate diagnoses; increase the utilization of mental health services by population groups that traditionally underutilize services; and change perceived negative encounters that are often experienced by population groups that seek treatment from systems that often do not provide culturally sensitive and competent services. It is, therefore, in the best interest of both mental health consumers and the public mental health system which serves them, that culturally competent services be consistently available, accessible and effective.

In recognition of this fact, NASMHPD supports states in their ongoing efforts to become more culturally competent in the provision of mental health services to ethnic, racial, linguistic, and culturally diverse populations. Services to these individuals should be based on concepts, policies, and procedures that provide a voice and choice; they should be flexible, individualized, and promote respect, dignity, and recovery. NASMHPD fully supports States' efforts to recruit and retain mental health professionals and paraprofessionals who can both represent these groups and understand their mental health needs and deliver the most effective methods of successfully responding to them.

NASMHPD is committed to working with states, representatives of culturally diverse communities and all care providers to explore ways to improve services and supports for these mental health consumers and their families. These efforts may include, but are not limited to: developing and disseminating information and technical assistance on best practices in culturally

competent services; providing forums for state and national dialogues on the need for and effective provision of culturally competent mental health services; and cooperating with other State and national organizations to develop research, education, training and performance-based initiatives to ensure the provision of culturally competent mental health services.

Approved by the NASMHPD membership on June 6, 2000.

Appendix B:

Panel Members and Planners Contact Information

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