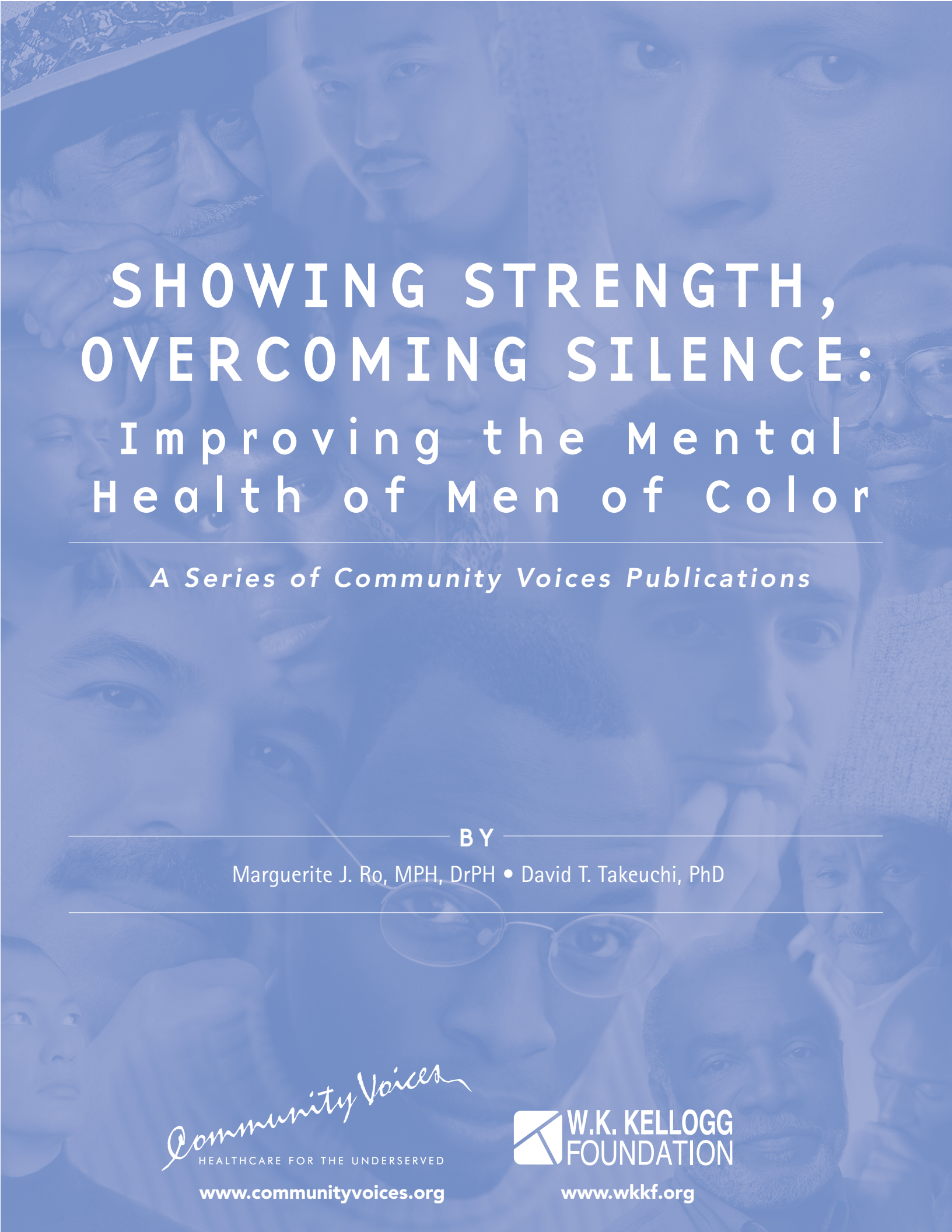

SHOWING STRENGTH, OVERCOMING SILENCE:

Improving the Mental Health of Men of Color

A Series of Community Voices Publications

BY

Marguerite J. Ro, MPH, DrPH • David T. Takeuchi, PhD

Community Voices

HEALTHCARE FOR THE UNDERSERVED

www.communityvoices.org

W.K. KELLOGG FOUNDATION

www.wkkf.org

SHOWING STRENGTH, OVERCOMING SILENCE:

Improving the Mental Health of Men of Color

A Series of Community Voices Publications

JULY 2003

BY

Marguerite J. Ro, MPH, DrPH • David T. Takeuchi, PhD

Prepared for

W.K. KELLOGG FOUNDATION

The National Center for Primary Care is the program office for the Community Voices initiative. www.msm.edu/ncpc. Community Voices is a multi-year initiative of the W. K. Kellogg Foundation designed to improve healthcare access and quality. The initiative involves 13 learning laboratories across the nation and is targeted atensuring the survival of safety-net providers and strengthening community support services.

Table of Contents

About the Authors

Marguerite Ro, MPH, DrPH, an Assistant Professor at Columbia University's Mailman School of Public Health and School of Dental and Oral Surgery, works primarily on improving access and utilization of health services by vulnerable populations. She is the author of a recent commentary titled "Moving Forward: Addressing the Health of Asian American and Islander Women" and is a co-author on a recent policy brief addressing the health of men of color "A Poor Man's Plight: Uncovering the Disparity in Men's Health." With the W. K. Kellogg Foundation's Community Voices Initiative, she works with 13 community collaborations on informing policy to improve access to oral health, mental health, and general health services. Addressing the social determinants of health, including social capital, class disparities, and racial/ethnic disparities are major components of her research and the policy technical assistance that she provides. In addition, she provides program management for the national American Legacy Foundation/Community Voices Tobacco Initiative and is a principal faculty member in Columbia's Oral Health Disparities and Policy Center.

David Takeuchi, PhD holds a joint position as Professor in the School of Social Work and Department of Sociology at the University of Washington. He is a sociologist with postdoctoral training in epidemiology and health services research. His research focuses on investigating the social, structural, and cultural contexts that are associated with different health outcomes, especially among racial and ethnic minorities. He also examines the use of health services in different ethnic communities. He has published in a wide range of journals including the American Journal of Psychiatry, American Journal of Public Health, Archives of General Psychiatry, Contemporary Sociology, Journal of Community Psychology, Journal of Health and Social Behavior, Sociology of Education, and Social Forces. In addition to his scholarly work, he has worked with a number of national and community organizations.

Acknowledgements

The authors gratefully acknowledge the support of the W. K. Kellogg Foundation. We thank Amy M. Yamashita for providing the essential research for this policy brief.

Statement of the Issues

Men of color are a rapidly growing segment of the U.S. population. Comprising 28 percent of the male population in 2000, they are expected to increase 143 percent by the year 2050 when they will represent 47 percent of men. Hispanic and Asian American/Pacific Islander men represent the fastest growing groups of men.[1] While men of color have made significant progress in society, they still face many challenges.

The medical and behavioral sciences have recently focused on one such challenge – the state of men's mental health – and uncovered hidden secrets. Mental health disorders are pervasive and persistent. They can make the routines of life difficult and painful. At their worst, they can significantly shorten a person's life.

For a variety of individual and institutional reasons, men of color face significant barriers to quality mental health care and, for the most part, are not benefiting from the scientific advances in mental health. These barriers often lead men of color to delay treatment. When they finally enter treatment, men of color tend to enter care with more serious problems due, in part, to lack of early preventive or routine treatment. Receiving unequal treatment – fewer visits and inappropriate services – it is not surprising that the treatment outcomes for men of color are not up to par.

In addressing mental health issues, men (especially men of color) must challenge the cultural credos of strength and silence. Too often men of color view psychological distress and the treatment of it as a personal weakness or failure. They suffer in silence and mental disorders manifest in ways that sometimes lead to dire consequences for men, their families, and society at large.

Overview of Indicators and Trends

The Numbers

Mental illness is one of the most serious and least understood diseases of modern life. About 20 percent of Americans suffer from a mental disorder each year.[2] Depression is the most common mental health problem in the U.S. and is often used (as in this paper) to illustrate the depth and breadth of the problem.

One in ten men of color will suffer from major depression in their lifetime. Approximately 8 percent of men of color experience major depression each year. These are substantial numbers since many people do not seek treatment for their mental health problems. Only two-thirds of people with depression seek treatment and, of those who seek treatment, only 1 in 10 receives adequate care.[3]

Although African American men have lower rates of depression than white or Hispanic men, and men, in general, have lower rates of depression than women, these low numbers are likely to be an undercount. Prevalence estimates of mental illness are generally not representative of all men of color. For various reasons, including distrust and wariness of government or formal data collection and sampling procedures limited to non-institutionalized populations, men of color appear to be underrepresented in depression prevalence estimates.

Lower depression estimates may also reflect the fact that men often present their depressive symptoms differently than women. Women often express their depression through feelings of sadness, worthlessness, and excessive guilt, while men may express distress through physical illness, drug or alcohol abuse, and antisocial or other high-risk behaviors (e.g., smoking, gambling, hypertension, diet, physical inactivity, unprotected sexual activity).[4] It has long been suspected that high rates of substance abuse and smoking are related to major depression in men. Men with depression also tend to report problems with fatigue, irritability, sleep disturbances, or loss of interest in work or hobbies. These gender differences in presenting problems – leading to inaccurate diagnoses for men and screening questions which focus too heavily on psychological symptoms – have significantly failed to identify men with mental disorders.[5]

Getting into Care

Men are less likely to seek care than women. Older Asian American men are more likely to enter treatment through a social service referral while younger Asian Americans enter through interpersonal means (self-referral, family, or friends).[6] Men of color, particularly African Americans, are more likely than white men to be referred to mental health treatment through coercive means.[7, 8, 9] This is especially true for younger African American males who are often referred through social and legal systems.

When entering treatment through voluntary means, such as self-referral, 75 percent of those with a mental health problem first seek out a primary care physician.[10] Among patients with depression, 90 percent are treated by health care providers.[11] For this reason, primary care physicians are often seen as the "gatekeepers" to treatment.

Another important community-based source for men of color is the clergy. Forty percent of people with a mental health problem turn to the clergy for direction and help.[12, 13] The clergy and other community-based sources of care serve a vital function since men are less inclined than women to seek treatment from a mental health specialist such as a psychiatrist or an outpatient clinic.[14, 15]

Emergency rooms also serve as entry ways to mental health care for men of color, especially for African American men and those who are uninsured.[16, 17] Disturbingly, data from emergency room visits indicate differential treatment – African American men receive *lower* actual evaluation time in emergency rooms compared to others.[18, 19] The high use of the emergency room is also related to coercive entry to services. The police are involved in more than one-third of emergency room admissions[20] and this police involvement has been found to correspond to higher rates of involuntary psychiatric hospitalization for men of color.[21, 22,23,24]

Barriers to Treatment

Stigma. The Surgeon General identified stigma as the "most formidable obstacle to future progress in the arena of mental health"[25] because it impedes men from accessing the care they need. As indicated by studies of African American men, concerns about stigma often cause men to delay or drop out of treatment, even when they perceive a need for help.[26] On the professional side, providers, such as primary care physicians, are also affected by stigma because it hinders them from appropriately diagnosing and treating disorders.

Lack of training and coordination among service providers. The primary care physician is an important resource for people seeking help. Unfortunately, primary care physicians often lack the training to diagnose mental health disorders, and the results have a profound effect on men of color. One study found that physicians were able to accurately identify only 67 percent of patients with depression. If the depression occurred in conjunction with a general medical illness, the physicians' accuracy dropped to 29 percent.[27] Cultural and racial differences between physician and patient may compound the diagnostic challenge. Evidence suggests that when patients differ racially and culturally from primary care providers, they tend to receive fewer mental health services.[28]

There is limited financial incentive for primary care physicians to treat depression. The already difficult task of diagnosis is further complicated by a population of men who may present with complex or more serious problems resulting from lack of early diagnosis and treatment. Treatment plans are time consuming to develop and implement and insurance reimbursement rates are minimal and restrictive. The structure of the managed care system often serves as a disincentive to refer patients for more specialized psychiatric care and further impedes the coordination of vital services for patients.

The clergy are a valuable and trusted source of community-based social support, assistance, and information. They are an important contact for 40 percent of people seeking help for a mental health problem. Yet a study in the mid-1980s noted that among 8 groups of mental health providers, the clergy was the least able to identify suicide lethality,[29] and they referred only 10 percent of the people seeking help to a specialist.[30, 31] There is an important need to link the clergy to clinical mental health services to ensure those with serious mental illnesses receive appropriate treatment.

Lack of insurance coverage. In addition to attitudinal barriers, institutional barriers prevent men of color from accessing services and receiving care in a timely manner. One of the most notorious barriers is health insurance — or the lack of it. Men are less likely than women to have health insurance. Hispanic men (46 percent) are more than twice as likely to be uninsured as white men (17 percent) and 28 percent of African American and 26 percent of Asian American/Pacific Islander men are uninsured.[32]

Most of the insurance coverage in the U.S. is offered through job-based programs. Yet many men, particularly lower income men, work in jobs that do not offer employer-sponsored health insurance. These include part-time, temporary, and contract jobs. Despite being employed at higher rates, Hispanic men tend to work for small businesses or businesses that do not offer health insurance. Even when job-based health insurance is available, Hispanic men, like many men of color,

cannot afford to pay the premiums and, once again, fall to the wayside of the uninsured.[33]

The Medicaid program serves as the safety net for families in poverty, but its benefits are generally not available to adults without dependent children. Even qualified immigrants are reluctant to apply for Medicaid erroneously believing it will impact future citizenship applications or for fear they will have to repay the benefits at a later date.[34]

The Indian Health Service is intended to close the insurance gap for American Indians/Alaska Natives, yet only one out of five is covered through the health plan because a majority of the population does not live within easy access to the service areas (reservations).[35]

Mental health parity. Even if people can afford health insurance, it is not always possible to receive adequate mental health care from current health benefit plans. Many insurance companies either exclude mental health services from health care packages altogether or impose severe restrictions on the amount and types of services people can purchase. Restrictions can include limitations on the number of inpatient days and outpatient visits for mental health treatment and biased reimbursement schedules. For example, private health insurance coverage for mental disorders is often limited to 30-60 inpatient days per year, compared to 120 days or unlimited days for physical illnesses. Optimally effective psychotherapy is generally delivered in 12-20 sessions, yet this widely accepted standard often exceeds the limits of health care plans.[36]

Managed care. Managed care organizations may decrease access into mental health care by their concentrated efforts to control costs. The person of color and physician of color who live or work in poor communities do not coincide with the targeted "ideal populations" of managed care organizations by virtue of their high costs. Since the poor are less likely to receive preventive care and they live in "high-stress" or "high-risk" environments, they are viewed as expensive, high users of health care. For similar reasons, managed care companies limit access to physicians of color, especially those who work in low-income communities. Recent research has shown that physicians of color are more willing to treat patients of color, Medicaid patients, and the uninsured.[37] As a result, they are likely to have complex cases that require extensive procedures, large volumes of medication, and multiple referrals. From a managed care perspective, the profile of patients for a physician of color goes against the preference for an "ideal physician": one who performs low-cost procedures and prescribes few medications.[38] Driven by considerations to contain costs, managed care companies discourage high-end users and providers of underserved populations from participating in plans, thus perpetuating racial and economic disparities in access to mental health care.

Language. Non- or limited-English speakers make up 18 percent of the total U.S. population and language is a major deterrent to service for this population.[39] Half the Asian American/Pacific Islander population is hampered in their efforts to access mental health care because of a language barrier.[40] Thirty-nine percent of the Hispanic population was born in a foreign country,[41] many of whom cannot access needed services because they cannot communicate in English.

CONSEQUENCES

MEN ARE NOT BEING SCREENED AND ARE NOT GETTING EARLY TREATMENT FOR MENTAL DISORDERS

The failure to receive early outpatient care seems to be related to increasing rates of hospitalization and lengths of stay among men of color. The barriers to treatment and inattention to societal stressors that impact men of color, particularly African American men, may be resulting in disproportionate numbers of men of color being institutionalized in mental and correctional facilities.

Little research has been conducted on determinants of severe mental illness among inmates, particularly reasons for the grave disparities by race. The inpatient treatment rate for male prisoners is double the rate that occurs in the general population of males, suggesting the presence of more severe psychological problems.[42, 43] Other estimates suggest that one in seven male prisoners has a psychotic illness or major depression, and one in two male prisoners has an antisocial personality-disorder.[44] What remains to be examined is how much of the severe mental illness among inmate populations is preventable and whether the high rates of mental illness especially among inmates of color reflects systemic or cultural biases among providers and within diagnostic instruments.

Increase of Misdiagnosed Cases and Inadequate Treatment

Large epidemiologic surveys of people in the community suggest that the true rates of schizophrenia in the general population are similar between people of color and whites.[45] Yet African Americans continue to be overdiagnosed and, to a lesser extent, Asian Americans and Hispanics – especially men – as schizophrenic.[46, 47] Research studies between the 1970s and 1990s report misdiagnosed schizophrenia rates as high as 86 percent among African Americans.[48, 49] Evidence suggests that doctors do not elicit enough information to make the appropriate diagnosis when working with African American patients and doctors are not considering the cultural context of the symptomatology exhibited. This is especially true when the race of the physician and patient differ – doctors do not give as many prompts for information, nor are doctors attuned to nonverbal or emotional cues.[50]

Racism and distrust also compound and affect the process of proper diagnosis and treatment. In its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare" (2003), the Institute of Medicine found evidence that stereotyping, biases, and uncertainty on the part of health care providers continue to result in disparate treatment for people of color. Men of color have a long and checkered history of health care service which has led to deep fears and mistrust of health care providers. This is particularly true of African American men.[51] Some of the most profound concerns swirl around the fear of involuntary commitment. Racial stereotyping, hostility, and distrust are factors leading to the misdiagnosis of schizophrenia among African American men and the excessive medication and restraints used on African American men with mental disorders.[52]

Hispanics and African Americans are 50 percent less likely to receive needed treatment than whites.[53, 54, 55] Whites have more than three times as many visits for high-intervention services staffed by psychiatrists/psychologists as African Americans or Hispanics.[56] African Americans are more often assigned to low-intervention services staffed by mental health workers rather than specialists/psychiatrists. Are African Americans being seen by the appropriate level of providers? The lower rates of satisfaction and successful treatment suggest that the answer is no.

Questions remain about whether people of color receive appropriate medication. Early studies suggested that people of color were overmedicated as a racial response to control "deviant" behavior and not as an effort to improve mental health status. Current research studies suggest that people of color are less likely to receive newer, more effective drugs in the treatment of psychiatric disorders, and when they do receive medication, the dosages are often over-prescribed.[57, 58, 59, 60]

As noted earlier, restrictions in health insurance plans discourage referrals for specialized psychiatric services and reduces the likelihood of appropriate treatment.

Premature Death

Men of color have shorter life expectancy rates than the national average for men (76.7 years) and white men (74.5 years). Hispanic men can expect to live 4.9 years less than white men. African American men have a life expectancy of 67.6 years compared to the national average of 76.7 years and American Indian/Alaska Native men have the lowest life expectancy rates among all men – 66.1 years. One of the causes of the shorter life span is a high rate of suicide among some men of color. Men are over four times more likely to die from suicide as women, and suicide is one of the top 10 causes of death among men.[61] It is the second leading cause of injury-related deaths for American Indian/Alaska Native and Asian American/Pacific Islander males. An estimated 80-90 percent of suicide deaths can be attributed to a serious mental disorder.[62] While suicide rates for most men have plateaued in recent years, the rates dramatically increased for three specific groups of men between 1999 and 2000: Asian American/Pacific Islander men age 65+ increased by 17 percent; American Indian/Alaska Native men age 65+ increased 22 percent; and Hispanic men age 15-24 years increased by 11 percent.

Depression is also linked to high rates of heart disease. Patients with a history of depression are four times more likely to have a heart attack than patients without depression[63] and it is considered a risk factor on par with obesity, tobacco, and high cholesterol. Heart disease is the leading cause of death for men of all races.

Costs

Depression is one of the 10 costliest illnesses in the U.S.[64] and one of the most burdensome diseases in the world.[65] The direct costs of mental health services and

treatment were estimated to be $12 billion annually in 1990. Another $8 billion was estimated to be the cost of premature deaths due to depression[66] and $44 billion in productivity losses for employers. Workers with depression cost employers 42 percent more in productivity losses than workers without depression.[67] As incredible as it seems, these are underestimates of the true situation because it excludes costs paid directly by the individual. A subsequent analysis revealed a $4 billion per year benefit (mostly to employers) if depression were accurately identified and treated.[68]

Strategies to Improve Mental Health Care

Reduce Stigma Through Health Education and Public Awareness Campaigns

Targeted efforts toward reducing stigma among men of color are needed. Community-based campaigns should be tailored to the social and cultural environment of the community in addition to being responsive to issues of masculinity and manhood.

Improve Access to Screening and Preventive Care

Deleterious outcomes may be avoided with screening and early treatment. Screening tools should be tailored for various populations, accounting for differences in symptomology by ethnicity. Outreach to men of color should be conducted by trusted community messengers.

Develop Cultural and Mental Health Competencies

Educate primary care physicians and other front-line service providers to recognize the different symptoms presented by men of color and develop appropriate treatment plans. Seventy-five to ninety percent of people with mental health concerns turn to a primary care physician as the first point of contact. The responsibility of being a "gatekeeper" to mental health services demands that physicians (a) recognize non-traditional symptoms of depression and other forms of mental illness; (b) routinely screen for depression among high-users of health services; and (c) develop communication skills to elicit detailed and accurate information from patients which, in turn, will lead to more accurate diagnoses.

Develop Mental Health Care Performance Standards for Insurers

Identify and develop standards of performance for mental health care which are similar to protocols for physical illnesses. These standards should include percentages of patients screened, diagnosed, receiving medication, and referred to mental health specialists. Deviations from expected numbers and percentages of patients served should be reviewed.

Referrals to specialists, type and length of treatment and follow-up, and medication protocols should coincide with accepted standards of practice by the American Psychiatric Association, American Psychological Association and the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality.

Increase the Diversity of the Mental Health Workforce

Although the number of ethnic service providers is relatively low, research on ethnic-matching has yielded encouraging results. For example, there are only 70 Asian American/Pacific Islander (AA/PI) providers for every 100,000 AA/PI compared to 173 per 100,000 in the white population. Only 2 percent of psychiatrists, 2 percent of psychologists, and 4 percent of social workers identify themselves as African American. [69]

Providers of color are more likely to treat patients of color and are more likely to work in geographic areas of high need. It is particularly important in addressing mental disorders that patients have a good working relationship with their provider. Ethnically matched providers may be more likely to share similar backgrounds, cultural norms, and values with their patients than other providers, facilitating communication and trust between patients and providers. There is a critical need for multilingual providers. Indeed, the presence of ethnically congruent providers seems to increase the rate of self-referrals and referrals by family and friends. Additionally, people of color remain in treatment for longer periods of time when being served by providers of similar ethnicity.[70, 71, 72]

Ethnic service providers are more prevalent at the lower intervention levels as aides and counselors, and less prevalent at the higher levels as psychiatrists or psychologists. Ethnic service providers are needed at all levels, particularly at the specialist level (psychiatrists and psychologists) to treat as well as to inform practice and training.

Recognize and Support the Role of the Clergy as an Important Mental Health Resource

Forty percent of the population turns to the clergy for help with mental health problems. The clergy are accessible to and often more culturally aligned with the community than other mental health resources. Mental health training for clergy could include the use of diagnostic screening material and information about how and when to make referrals to mental health specialists.

Examine Issues Related to the Availability and Appropriateness of Medication

Even for those with insurance coverage, access to newer medications with fewer side effects may be limited due to drug formularies. For those without insurance, the high cost of medication particularly newer drugs is unaffordable. Among mental health specialists, dispensing medication is limited to psychiatrists. This may be a barrier to medication since there are so few psychiatrists and even fewer psychiatrists of color. In geographical areas where access to psychiatrists is limited, options for dispensing medications through other specialists should be examined. In addition, practice guidelines and quality assurance efforts need to address the problem of over-prescribing medications to people of color.

Develop a Coordinated System of Care

Linkages among criminal justice, substance abuse treatment facilities, human services, clergy and faith-based organizations, health care providers, and mental health providers are needed to ensure that there are multiple entry ways to care and that individuals can be referred to the appropriate level of providers. A coordinated care system is also important in creating a support system that doesn't allow individuals to fall through the gaps.

Build the Knowledge Base on Mental Health and Men of Color

There is very little data or published research on the mental health status and needs of men of color. The portrait of mental health status among men of color is deduced from two separate collections of research: (1) ethnic/race research and (2) gender research. Historically, men of color have low response rates in survey research studies and it is difficult to capture the needs of this diverse group.

Comprehensive data needs to be routinely collected and reported for the general population of men as well as institutionalized men in order to capture the true depth of need of the different groups. There is presently great variability in screening, diagnostic, and treatment services among mental health facilities (including correctional facilities), suggesting a large unmet need among men of color.

Conclusion

Mental health disorders are pervasive and extensive. They touch on virtually every part of a person's life. To address each barrier independently would be to ignore the complex interplay among social, cultural, and psychological factors that influence mental health and mental illness. While the recommendations above are listed separately, it is important to remember that each one is related to the others and must be viewed as an intricate thread woven through the fabric of mental health services for men of color.

References

1. U.S. Census Bureau. (2000). *Projections of the resident population by age, sex, race, and Hispanic origin: 1999-2100.* (NP-D1-A) U.S. Washington, DC: Department of Commerce, U.S. Census Bureau, Population Division.
2. U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General, 1999.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
3. Robins, L.N., & Regier, D.A. (1999). *Psychiatric disorders in America: The epidemiologic catchment area study.* New York, NY: Free Press.
4. U.S. Department of Health and Human Services. (2003). *Men and depression. NIH Publication No. 03-4972.* Washington, DC: National Institute of Mental Health.
5. Birchall, H., Brandon, S., & Taub, N. (2000). *Panic in a general practice population: Prevalence, psychiatric comorbidity and associated disability.* Social Psychiatry and Psychiatric Epidemiology, 35(6), 235-241.
6. Takeuchi, D., & Cheung, M.K. (1998). *Coercive and voluntary referrals: How ethnic minority adults get into mental health treatment.* Ethnicity and Health, 3(3), 149-158.
7. Chow, J.C., Jaffee, K., & Snowden, L. (2003). *Racial/ethnic disparities in the use of mental health services in poverty areas.* American Journal of Public Health, 93(5), 792-797.

8. 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, Public Health Office, Office of the Surgeon General.
9. Takeuchi & Cheung, 1998.
10. Goldman, L.S., Nielsen, N. H., & Champion, H.C. (1999). *Awareness, diagnosis, and treatment of depression.* Journal of General Internal Medicine, 14, 569-580.
11. Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K.R., Rush, A.J., Walters, E.E., & Wang, P.S. (2003). *The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication* (NCS-R). Journal of the American Medical Association, 289(23), 3095-3105.
12. Meylink, W.D., & Gorsuch, R.L. (1988). *Relationship between clergy and psychologists: The empirical data.* Journal of Psychology and Christianity, 7, 56-72.
13. Veroff, J., Douvan, E., & Kulka, R.A. (1981). *The inner American: A self-portrait from 1957 to 1976.* New York: Basic Books.
14. Pingitore, D., Snowden, L., Sansone, R.A., & Klinkman, M. (2001). *Persons with depressive symptoms and the treatments they receive: A comparison of primary care physicians and psychiatrists.* International Journal of Psychiatry in Medicine, 31(1), 41-60.
15. Husaini, B., Sherkat, D.E., Levine, R., Bragg, R., Holzer, C., Anderson, K., Cain, V., & Moten, C. (2002). *Race, gender, and health care service utilization and costs among Medicare elderly with psychiatric diagnoses.* Journal of Aging and Health, 14(1) 79-95.
16. Chow et al., 2003.
17. Dhossche, D.M., & Ghani, S.O. (1998). *Who brings patients to the psychiatric emergency room?* Psychosocial and psychiatric correlates. General Hospital Psychiatry, 20, 235-240.
18. Dunn, J., & Fahy, T.A. (1990). *Police admissions to a psychiatric hospital: Demographic and clinical differences between ethnic groups.* British Journal of Psychiatry, 156, 373-378.
19. Segal, S.P., Bola, J.R., & Watson, M.A. (1996). *Race, quality of care, and antipsychotic prescribing practices in psychiatric emergency services.* Psychiatric Services, 47, 282-286.
20. Dhossche & Ghani, 1998.
21. Dhossche & Ghani, 1998.
22. Claassen, C.A., Gilfillan, S., Orsulak, P., Carmody, T.J., Battaglia, J., & Rush, A.J. (1997). *Substance use among patients with a psychotic disorder in a psychiatric emergency room.* Psychiatric Services, 48, 353-358.
23. Snowden, L.R., & Holschuh, J. (1992). *Ethnic differences in emergency psychiatric care and hospitalization in a program for the severely mentally ill.* Community Mental Health Journal, 28(4), 281-291.
24. Rosenfield, S. (1984). *Race differences in involuntary hospitalization: Psychiatric vs. labeling perspectives.* Journal of Health and Social Behavior, 25(1), 14-23.
25. U.S. Department of Health and Human Services, 2003.
26. Cooper-Patrick, L., Powe, N.R., Jenckes, M.W., Gonzales, J.J., Levine, D.M., & Ford, D.E. (1997). *Identification of patient attitudes and preferences regarding treatment of depression.* Journal of General Internal Medicine, 12(7), 431-438.
27. Tylee, A.T., Freerling, P. & Kerry, S. (1993). *Why do general practitioners recognize depression in one woman patient yet miss it in another?* British Journal of General Practice, 43, 327-330.
28. Wang, S., Berglund, P. & Kessler, R. (2000). *Recent care of common mental disorders in the United States.* Journal of General Internal Medicine, 15, 284-292.
29. Williams et al, 1999.
30. Meylink & Gorsuch, 1988.
31. Veroff, J., Douvan, E., & Kulka, R.A. (1981). *The inner American: A self-portrait from 1957-1976,* New York: Basic Books.
32. Brown, E.R., Ojeda, V.D., Wyn, R., & Levan, R. (2000). *Racial and ethnic disparities in access to health insurance and health care.* Los Angeles, CA: UCLA Center for Health Policy Research.
33. Brown et al., 2000.
34. Kaiser Family Foundation. (2000). *Health insurance coverage and access to care among Latinos.* Washington, DC: Author.
35. Kaiser Family Foundation. (2000). *Health insurance coverage and access to care among American Indians and Alaska Natives.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.
36. Goldman et al., 1999.
37. Komaromy, M., Grumbach, K., Drake, M., et al. (1996). *The role of black and Hispanic physicians in providing health care or underserved populations.*[comment]. New England Journal of Medicine, 334, 1305-1310.
38. Harvard Law Review. 1995. *The impact of managed care on doctors who serve poor and minority patients.* Harvard Law Review, 108, 1625-1642.
39. U.S. Census Bureau. (2003). *Census 2000 summary file 3,* matrices P18, P19, P21, P22, P24, P36, P37, P39, P42, PCT8, PCT16, PCT17, and PCT19. http://www.census.gov
40. U.S. Department of Health and Human Services, 2001.
41. Therrien, M., & Ramirez, R.R. (2000). *The Hispanic population in the United States: March 2000.* Washington, DC: U.S. Census Bureau, Current Population Reports, Series P20-535.
42. Fazel, S., & Danesh, J. (2002). *Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys.* The Lancet, 359, 545-550.
43. Beck, A.J., & Maruschak, L.M. (2001). *Mental health treatment in state prisons, 2000.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, NCJ 188215.

44. Fazel & Danesh, 2002.
45. Robins, L.N., & Regier, D.A. (1991). *Psychiatric disorders in America: The epidemiologic catchment area study.* New York, NY: Free Press.
46. Strakowski, S. (2003). *How to avoid ethnic bias when diagnosing schizophrenia.* Current Psychiatry, 2(6), online.
47. Husaini et al., 2002.
48. Mukherjee, S., Shukla, S., Woodle, J. et al. (1983). *Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison.* American Journal of Psychiatry 140, 1571-1574.
49. Strakowski, S.M., Shelton, R.C., & Kilbrener, M.L. (1993). *The effects of race and comorbidity on clinical diagnosis in patients with psychosis.* Journal of Clinical Psychiatry, 54, 96-102.
50. Strakowski, 2003.
51. Jones, B.E., & Gray, B.A. (1986). *Problems in diagnosing schizophrenia and affective disorders among blacks.* Hospital and Community Psychiatry, 37, 61-65.
52. Lawson, W.B. (1986). *Racial and ethnic factors in psychiatric research.* Hospital and Community Psychiatry, 37, 50-54.
53. Claassen et al., 1997.
54. U.S. Conference of Mayors. (2002). *A status report on hunger and homelessness in American cities: 2001.* Washington, DC: Author.
55. Wells, K., Klap, R., Koike, A., & Sherbourne, C. (2001). *Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care.* American Journal of Psychiatry, 158, 2027-2032.
56. Claassen et al., 1997.
57. U.S. Department of Health and Human Services, 2001.
58. Chen, R.S., Nadkarni, P.M., Levin, F.L. (2000). *Using a computer database to monitor compliance with pharmacotherapeutic guidelines for schizophrenia.* Psychiatric Services, 51, 791-794.
59. Owen, R.R., Feng, W.W., Thrush, C.R., et al. (2001). *Variations in prescribing practices for novel antipsychotic medications among veterans affairs hospitals.* Psychiatric Services, 52, 1523-1525.
60. Kuno, E., & Rothbard, A.B. (2002). *Racial disparities in antipsychotic prescription patterns for patients with schizophrenia.* American Journal of Psychiatry, 59, 567-572.
61. Centers for Disease Control and Prevention. (2002). *Web-based injury statistics query and reporting system (WISQARS)* [online]. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available from: URL: www.cdc.gov/ncipc/wisqars. [2003 March 27].
62. U.S. Department of Health and Human Services, 1999.
63. Mok, H., & Lin, D. (2002). *Major depression and medical comorbidity.* Canadian Psychiatric Association Bulletin, 34, 25-28
64. Hirschfeld, R.M., Martin, B., Panico, S., Arons, B., Barlow, D., Davidoff, F., Endicott, J., Froom, J. et al. (1997). *The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression.* Journal of the American Medical Association, 277, 333-340.
65. World Health Organization. (2002). *The world health report 2002: Reducing risks, promoting healthy life.* Geneva, Switzerland: Author.
66. Greenberg, P., Stiglin, L., Finkelstein, S., & Berndt, E.R. (1993) *The economic burden of depression in 1990.* Journal of Clinical Psychiatry, 54(11), 405-418.
67. Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S. & Morganstein, D. (2003). *Cost of lost productive work time among U.S. workers with depression.* Journal of the American Medical Association, 289(23), 3135-3144.
68. Rupp, A. (1995). *The economic consequences of not treating depression.* British Journal of Psychiatry, 166, 29-33.
69. Center for Mental Health Services. (2000). *Mental health, United States, 2001.* Manderscheid, R.W., & Henderson, M. J. (eds.). DHHS Pub. No. (SMA) 01-3537. Washington, DC: Superintendent of Documents, U.S. Government Printing Office.
70. Akutsu, P., Snowden, L., & Organista, K. (1996). *Referral patterns in ethnic-specific and mainstream programs for ethnic minorities and whites.* Journal of Counseling Psychology, 43, 56-64.
71. Sue, S., Fujino, D., Hu, L.,Takeuchi, D., & Zane, N. (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.
72. Takeuchi, D., Sue, S. & Yeh, M. (1995). *Ethnic-specific services: Do they work?* American Journal of Public Health, 85, 638-643.

W.K. KELLOGG
FOUNDATION

One Michigan
Avenue East
Battle Creek, MI
49017-4058
USA
269-968-1611
TDD on site
Telex: 4953028
Facsimile: 269-968-0413
Internet: http://www.wkkf.org

CV:HCULM4000
Item #570
7-03