

WORLD FEDERATION FOR MENTAL HEALTH
**REPORT OF AN INTERNATIONAL EXPERTS
FORUM ON REDUCING DISPARITIES IN
MENTAL HEALTH SERVICES FOR RACIAL
AND ETHNIC MINORITIES**

Minneapolis, Minnesota, USA
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World Federation for Mental Health
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World Federation for Mental Health (2009)

The information in this report represents a summary of discussions from a WFMH International Experts Forum held in Minneapolis, Minnesota, on December 17 – 19, 2008. The purpose of this meeting was to bring together a group of leaders working on issues to reduce the continuing and widening disparities in access to culturally appropriate mental health services by racial and ethnic minorities, and to develop recommendations as to how WFMH might be able to address these issues through its advocacy, education, and constituency development strategies within its Transcultural Mental Health Initiative. This report can be accessed and downloaded from the WFMH website at www.wfmh.org.

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THE WORLD FEDERATION FOR MENTAL HEALTH

The World Federation for Mental Health convened an International Experts Forum on Reducing Disparities in Mental Health Services for Racial and Ethnic Minorities in Minneapolis, Minnesota, on December 17-19, 2008. The Forum was a component of the 2008 continuation program of work for the WFMH Center for Transcultural Mental Health (CTMH).

- The Forum was organized as a first step in the Center's efforts to focus increased attention on the crisis of growing disparities in access to mental health services by racial and ethnic minorities and people from immigrant cultures, to determine what can be done to address this crisis, and reduce the current gaps in service availability and accessibility. The International Experts Forum brought together key experts in health disparities in order to gain perspective and provide recommendations and guidance on how the WFMH CTMH can develop the expertise and networks needed to play a leadership role on this issue.

Some of the issues that were considered during the Forum included:

- *Mental health service disparities around the world; defining the extent of the problem*
- *The need to provide for the influence of race and culture on service planning and provision*
- *Disparities in mental health services for racial and ethnic minorities in the U.S. and other Western countries*
- *Disparities in the inclusion of minorities in research and clinical trials*
- *Barriers to providing for minorities in mental health services and including them in research*
- *Ways to overcome barriers in service provision for minorities and to encourage their participation in research*
- *Call to action for all stakeholders*

Rationale for the Forum

Many racial and ethnic minorities in the United States and in other Western countries face great challenges in everyday life, ranging from language to culture, from economic status to social relations. Whether minorities come from other countries or are born in the country of current residence, they face adjustment and acceptance issues, racism, unemployment, language and cultural differences. These challenges also exist for a large percentage of the indigenous populations. Trauma and adjustment issues create an undeniable source of stress and, very often, ill health, both physical and mental.

In addition, the following issues are faced by minorities in their adopted country every day:

- *Problems with accessibility of mental health care*
- *Lack of participation of minorities in the development and delivery of services*
- *Uneven distribution of services*
- *Poor quality and quantity of data on minorities' mental health problems and use of services*

- *Short term and uncertain funding of specific services for minorities*
- *Scarce dissemination of the knowledge gathered by good practice*
- *Lack of research taking into account the unique cultural aspects of individuals, including a lack of clinical trials using the cultural variables required*
- *Lack of defined strategies for recruiting and including ethnic minorities in clinical trials for new medications and therapeutic techniques*

The information gathered from the Forum will provide the WFMH Center on Transcultural Mental Health (CTMH) with basic information and guidance for future work addressing these important issues. The information presented in this report summarizes the discussions at the Forum and provides a number of recommendations from the participants that will help the Federation's to develop future strategies..

The WFMH International Experts Forum on Reducing Disparities in Mental Health Services for Racial and Ethnic Minorities and Immigrants was made possible through an educational grant from Eli Lilly & Company. WFMH is most grateful for Eli Lilly's support for the work of the WFMH Transcultural Mental Health Initiative, of which this Experts Forum is a part. We are also extremely grateful to the members of the Experts Panel, who braved a major winter snowstorm while traveling to and from Minneapolis. WFMH volunteers Dr. L. Patt Franciosi and Charles G. Ray deserve special recognition for their service in chairing and facilitating the Forum, as does WFMH Director of the Office for Promotion and Prevention, Dr. Elena Berger, for her excellent authorship of this report.

Preston J. Garrison
Secretary General & Chief Executive Officer
World Federation for Mental Health
May 14, 2009

RECOMMENDATIONS

To improve access to mental health care for disadvantaged racial and ethnic minorities, integrate quality mental health services into primary care.

Address social as well as medical issues for people from vulnerable groups. Encourage government agencies to develop coordinated plans that address the social problems affecting minorities.

Make a systematic effort to encourage minority participation in research, with special attention to the increased cost and time entailed in such efforts. Minorities and immigrants should be included in clinical and behavioral research, and research on mental health promotion and mental disorder prevention, in order to expand the evidence base. Minority communities should be cultivated to win their interest in research.

Minorities should be consulted in the development of research programs. Their viewpoints should be respected and incorporated, if necessary, by combining qualitative and quantitative research.

Children and young people from racial and ethnic minorities should be included in research on child and adolescent mental health, since many mental and behavioral disorders are diagnosed at an early age.

Training for cultural competence is not a static concept, but an area of shifting demands that requires ongoing attention; the situations of communities and individuals can change rapidly. The concept of "cultural competence" should include language ability, familiarity with cultural customs and history, careful attention to social issues, and an ability to approach different cultures with respect, humility and empathy.

Develop training courses for the workforce according to the community to be served, and give special attention to training for the workforce serving multicultural areas. Include evaluation of program design and effectiveness.

Recruit more people from minority backgrounds to enter professional training.

Professionals providing care for people in minority groups who do not share their language should work with interpreters specially trained in mental health issues, and culture brokers who can provide guidance on community issues. They should investigate the use of videoconferencing when an interpreter is not available locally.

Increase awareness among doctors, staff and the public about the high level of co-occurrence of physical illnesses, mental illnesses, and substance abuse disorders, as well as risk factors for mental illness, and its age patterns.

Bearing in mind the age pattern of many mental disorders, health care providers in disadvantaged communities should provide mental health services for children and adolescents, with planning for consultation and referral to specialists in child and adolescent mental health.

Where possible, schools should be used as an important contact point for services, and for providing information about mental disorders to children, adolescents, their families and teachers.

Preventing students from dropping out of school should have high priority. Adolescent school drop-outs face mental health consequences.

The relevance of evidence-based mental health promotion initiatives and mental disorder prevention programs to minority groups should be carefully reviewed by government agencies. Where evidence-based programs are unsuited to the local circumstances of minority populations, consider rigorously reviewed practice-based and community-based mental health programs for specific local needs. Encourage the development of appropriate evidence.

Foster collaboration on mental health promotion and the prevention of disorders between the education sector and researchers working on child and adolescent mental health.

Consider including the arts valued in minority cultures in mental health promotion for them.

Expand the advocacy network as broadly as possible to address discrepancies in mental health care for minorities.

INTRODUCTION AND STATISTICS ABOUT MINORITY POPULATIONS

This report is the outcome of an Experts' Forum on reducing mental health disparities for racial and ethnic minorities, organized by the World Federation for Mental Health in Minneapolis, Minnesota, USA on 17-19 December, 2008. Participants discussed the situation in Canada, the United Kingdom and the United States, where there are acknowledged difficulties for racial and ethnic minority populations in accessing mental health services. In these countries minority groups form a growing part of the total populations. The Forum examined the reasons for problems of access, and made recommendations for improving mental health care that may be generally useful to other countries with similar problems in providing mental health care for racial and/or ethnic minorities.

The situations of minorities in the countries under review are very varied. Native American and Inuit communities in Canada and the United States are the original populations. There are considerable differences among tribal groups. The African American population in the United States is long established, dating from large-scale import of slaves. It has been supplemented by later immigration from Africa and the Caribbean islands. Black communities in the United States now differ greatly in circumstances and income levels, but a large number of African Americans live in marginal economic situations. In Canada and the United States other minorities reflect patterns of immigration from many parts of the world. In the United Kingdom, historic colonial connections have produced large communities of immigrants from the Caribbean, Africa and Asia.

These different groups may have little in common, but minority status itself contributes to barriers in obtaining mental health care. Mental health problems are relatively common in all populations, and additionally, many people from indigenous, racial and ethnic minorities live in adverse social circumstances which affect their health and contribute to mental disorders. The problems they experience in accessing mental health services can arise from geographic isolation or isolation in cities, lack of information about services, reluctance to admit to mental disorders, or mistrust of service providers. Their cultural background often differs from the mainstream culture. For a large number of foreign-born minorities there are language problems and difficulties of adjustment to a new country. Refugees and asylum seekers have often experienced violence and trauma, and consequently can have special difficulties. The Census figures below, though from different dates in the past decade, give an indication of the great variety within minority communities and of their importance within national populations.

In Canada, the 2006 Census reported that 3.8% of the total population of 31,241,030 had Aboriginal identity, including various North American Indian categories, Métis and Inuits.¹ The new Mental Health Commission of Canada found that Aboriginal peoples were disproportionately represented among the homeless and the mentally ill.² In the total population, the Census counted 19.8% as immigrants (6,186,950)—people born outside Canada, including those long settled there and more recent arrivals. Of the total number of immigrants, 7.5% came from the People's Republic of China, 3.5% from the Hong Kong Special Administrative Region, and 1.1% from Taiwan. Other Asian immigrants included 4.9% from the Philippines and 2.6% from Vietnam. Indians accounted for 7.2% of the immigrant total. Just over half of the immigrant population lived in Ontario (3,398,725),

followed distantly by British Columbia (1,119,215).³ In those provinces services must be provided to people with many different cultures and languages.

In the United Kingdom the network of colonies, succeeded by Commonwealth connections and other immigration, resulted in a minority ethnic population that was 7.9% of the country's total population of 58,789,194 as recorded in April 2001 Census. The overall total included 4.0% Asian or Asian British (Indians, Pakistanis, Bangladeshis and others); 2% Black or Black British (Africans, African Caribbean people and others) and 0.4% Chinese.⁴ In addition 1.2% of the total population reported that they were of mixed race.⁵ There has been considerable criticism of the provision of mental health services to black and minority ethnic communities (BME groups, as they are known in the United Kingdom).

In the United States the Census Bureau estimated the minority population in mid-2008 at 104.6 million, 34% of the national total of 304,059,724 people. The largest minority group was of Latino/Hispanic origin, totaling 46.9 million. African-Americans and other Blacks totaled 41.1 million. Asians of many national backgrounds totaled 15.5 million. American Indians and Alaska Natives totaled 4.9 million. Native Hawaiians and other Pacific islanders totaled 1.1 million. In addition 5.2 million people were of two or more races. According to the estimates 47% of all children under 5 came from minority groups (25% from Hispanic backgrounds).⁶

According to estimates from 2000, immigration to the United States produced a "foreign-born" category of 11.1% of the national total. Those above the age of five speaking a language other than English at home were 17.9% of the population.⁷ Census Bureau estimates from 2003 showed that 53.3% of the "foreign born" were from Latin America; 25.0% from Asia; and 13.7% from Europe.⁸ Immigrants from Mexico and elsewhere in Central America account for more than one third of the foreign-born population of the United States. Unlike the United Kingdom, where "Asian" usually covers people from India, Pakistan and Bangladesh (with those of Chinese origin counted separately), in the United States the Asian category covers people from all parts of Asia and South Asia.

The 2001 Supplement to the U.S. Surgeon General's Report on Culture, Race and Ethnicity pointed out many barriers to mental health care for minorities in the United States, and also highlighted the diversity within broad categories of minorities. The Hispanic/Latin American population includes people of Mexican, Puerto Rican, Cuban, Dominican and Spanish origin, as well as those from many South American countries. The Federal Government recognizes more than 500 American Indian and Alaska Native tribes speaking more than 200 languages, and there are many tribes that are not officially recognized. The Asian American/Pacific Islander category has some 43 ethnic subgroups speaking more than 100 languages and dialects. Some subgroups of recent immigrants (for example, Hmong, Cambodians and Laotians) speak little English. In contrast, there are many people of Japanese and Chinese origin who are 4th and 5th generation Americans.⁹

In addition to considering countries with varied racial and ethnic communities, there was considerable discussion at the WFMH Forum of mental health issues in the Caribbean (and particularly Jamaica), as an example of the complex historical issues that influence modern immigration. This region of many island nations experienced the long-term import of slave labor from different parts of Africa, and colonial rule by several European countries. Centuries of plantation society resulted in a loss of African identity, with a legacy of racial

mixing, unstable family patterns and widespread poverty. As a consequence of that poverty, in more recent times the island nations sent large numbers of immigrants to other countries, including Canada, the United Kingdom and the United States.

The population of the Caribbean was estimated at 40,248,416 in mid-2008. The population of Jamaica was estimated at 2,804,332, 7% of the Caribbean total.¹⁰ Approximately 85% of Jamaica's population is of African origin, with minority groups of Whites, Indians and Asians (about 5% each).

In Canada, the 2006 Census reported that people from the Caribbean and Bermuda accounted for 1% of the total population of 31,241,030, and 5.1% of the total immigrant population (317,765 out of 6,186,950).¹¹ About 30% of the country's Black population originates from Jamaica, and a further 32% originate from other Caribbean nations.

According to the United Kingdom's April 2001 census, Black people from the Caribbean numbered 565,875 or 1.0% of the total population. They represented half of the total Black population (most of the remainder being of African origin), and 12.2% of the overall non-White population.¹² People of Jamaican origin are the largest group in Britain's Caribbean community.

According to the U.S. Census Bureau, Caribbean-born people accounted for 10.1% of all of the foreign-born people in the United States in 2003.¹³ The 2000 Census showed that Caribbean-born people numbered 2,953,066, of whom 29.6% were from Cuba, 23.3% from the Dominican Republic, 18.8% from Jamaica and 14.2% from Haiti.¹⁴

IMPROVING ACCESS FOR DISADVANTAGED MINORITIES TO MENTAL HEALTH CARE

“Braiding the rope that creates a lifeline for reducing disparities.”

- DJ Ida

Recommendations

To improve access to mental health care for disadvantaged racial and ethnic minorities, integrate quality mental health services into primary care.

Increase awareness among doctors, staff and the public about the high level of co-occurrence of physical illnesses, mental illnesses, and substance abuse disorders, as well as risk factors for mental illness, and its age patterns.

Address social as well as medical issues for people from vulnerable groups. Encourage government agencies to develop coordinated plans that address the social problems affecting minorities.

Integrating Mental Health Services into Primary Care

Integrating quality mental health services into primary care is a key pathway to improving access to mental health services. For most racial and ethnic minorities, immigrants and indigenous people, general health care is provided through primary care, and although this may not be easily available, mental health care is usually even more difficult to find. Providing mental health care through primary care services is more than a matter of potential convenience. Since the co-occurrence of mental and physical disorders is frequent, it enables medical personnel to offer a holistic response to health needs. It can be a cost-effective way of providing mental health services, reducing the use of emergency rooms and psychiatric hospitals, and offering people effective care in their own community. Referrals to specialist mental health services should be available to provide a continuum of care.¹⁵

Willingness to seek mental health care is often hard for people from racial, ethnic or other minority backgrounds. Stigma presents a barrier, and knowledge about mental illness, treatment options and recovery is limited. Language barriers present major difficulties. Primary care offices and clinics need to make an effort to win the confidence of hard-to-reach groups and make their services acceptable to them.

Increasing awareness among doctors, their staffs and the public about the co-occurrence of physical illness, mental illness and substance abuse disorders strengthens the case for providing mental health care within primary care. Decision-makers, community leaders, and medical staff serving deprived communities should all become better informed about the reasons for having an integrated spectrum of care. People with illnesses such as diabetes, cardiovascular disease, cancer and HIV/AIDS are at higher risk for mental disorders, which should be treated as part of their general care. People with severe mental illnesses are at

higher risk for premature death, yet often fail to receive routine health care. They need attention for their physical health problems, including the side-effects of medication taken for mental illness. People with substance abuse disorders often have other health and mental health problems. Co-morbidity of illnesses is the norm, not the exception.¹⁶

Integrating physical and mental health care in primary care is a process that must be addressed carefully, but it does not need to conform to a single model. The World Health Organization (WHO) and the World Organization of Family Doctors (Wonca) have published a study of twelve countries around the world that have already integrated mental health care into their primary care networks. These countries vary greatly in their stages of economic development and have adopted different models that suit local circumstances. The study shows that a variety of approaches are possible; there is no single pattern that fits each context. WHO and Wonca also acknowledge the importance of informal care in the community alongside primary care.¹⁷

One of the models in the WHO/Wonca study shows that primary care can be adapted to provide physical and mental health care even for a particularly disadvantaged multicultural community. Waltham Forest in north-east London is home to many vulnerable groups living in poor circumstances, including immigrants, refugees, asylum seekers and homeless people. The Waltham Forest Primary Care Trust had established a special general practice to improve access to care for these vulnerable people, but later became worried that this was increasing exclusion and stigma. It arranged for two primary care practices in the area to absorb the patients and provide care for physical and mental health. Financial incentives were offered to enable the two practices to spend more time with these patients than with the regular list, and to provide contacts with appropriate social service agencies as well as specialist medical referrals as needed.¹⁸

The approach of one of the two practices, located in Walthamstow, is described in the WHO/Wonca study although both practices offer similar services. All of the new patients were invited for a general health exam by one of the practice nurses, who also collected information about housing, employment and other relevant social issues. As a result of this assessment a care plan was designed to address social as well as medical issues. The practice was appropriately staffed to cover mental health problems. Three of the ten doctors had specialized training in psychiatry, as had one of the four practice nurses. The additional workload could be handled because the practice's contract with the Primary Care Trust allowed it to give extra time for appointments with the new group of patients, including time to address psychosocial issues.¹⁹

The Walthamstow practice has expanded its efforts beyond the normal range of primary care tasks. It makes a considerable effort to educate its patients about mental illnesses, and about the availability of social services. It provides guidance on obtaining information, and works with local libraries to make resources available there. Computerized cognitive behavioral therapy is available. It puts selected patients in touch with job retention support, and is working to increase employers' understanding of mental illness in order to improve their attitude to people returning to work. It also urges employers to provide new job

opportunities for those who have had a mental illness. Consumer groups are consulted at regular intervals, and the practice arranges for peer group support.²⁰

In order to provide a social network for patients who are transferred to primary care after a hospital stay, a program coordinator meets with the patient at the hospital to discuss options based on social inclusion and reintegration into the community. The practice places great importance on finding volunteer opportunities for patients and also for members of the public who would like to work with them. A befriending program is provided.²¹

This practice's approach to providing mental health services has resulted in service redesign and renewed attention to staff training. Cultural competence is given a high priority during weekly in-service training sessions for all the practice staff.²²

“Self-care”

The World Health Organization and the World Organization of Family Doctors recommend that “most people be encouraged to manage their own mental health problems themselves, or with support from family or friends.”²³ According to this “self-care” model people should become involved in their own care whenever possible, in order to participate in collaborative decision-making with the health care provider, accepting responsibility for adhering to prescribed medication and changing health-related behaviors such as drug and alcohol use or managing stress.²⁴

An essential part of the “self-care” model calls for improving mental health literacy in the population to enable people to learn about disorders and treatments and where they can go for help. Education about mental disorders can motivate people to participate in “self-care.” It can be fostered through well-planned initiatives for mental health promotion to provide information for people in their own languages. This kind of public information campaign in a foreign language should have careful translation and back-translation to ensure that the material it conveys is presented in an appropriate way and does not offend the local community's sensibilities.²⁵

Attention to Families and Other Caregivers

Depending on a patient's individual situation, family members may or may not be closely involved. Sometimes, other caregivers are important. The World Health Organization and the World Organization of Family Doctors acknowledge the importance of informal community care.²⁶ Family and other caregivers from minority communities should be able to obtain appropriate information in their own languages to help them to understand mental illnesses. They also need information about useful resources, including local family/caregiver support groups if these exist.

Professional staff should pay attention to the particularities of family situations, bearing in mind that people from minority cultures may have different family lifestyles. For child and adolescent patients, parents are usually involved in care. In cases where a parent has a mental illness, the whole family can benefit from interventions designed to strengthen

relationships—when programs are available. There is an evidence base that shows specially designed programs are helpful for the children in such families. Occasionally a young person is directly involved in providing care for a mentally ill parent and could benefit from independent support. Adult children are often concerned when an older person has mental problems. For appropriate assistance to be offered to racial and ethnic minority families in different situations, staff need to be attentive to both cultural and language issues.

The emotional toll on families and other caregivers providing extensive support to people with mental illnesses is not often taken into consideration by service providers.²⁷

Social Background

Racial and ethnic minorities, immigrants, refugees and members of indigenous tribes have problems that may originate or be made worse by the situations in which they live. The World Health Organization's Commission on the Social Determinants of Health has produced powerful evidence of the impact of people's social situation on their health.²⁸ Social rank affects health, and minorities often have a low socioeconomic status. Health care workers should take account of poverty, inadequate housing, limited education and unemployment as they assess a person's mental health problems and the outlook for improvement. People in marginal circumstances have a variety of problems that interact. In addition to anxiety about supporting themselves and their families, they are often concerned about neighborhood crime and violence. Illegal immigrants worry about the uncertainty of their lives and their futures.²⁹

When considering the social issues that may be associated with an individual's mental health problems, health care providers should allow some extra time for discussion with the person. Vulnerable people may not have information about social welfare agencies that could provide assistance, or how to apply for it. They may not have the language ability to do so, or transport to reach an agency office. Health workers should take a broad view of mental health issues and be able to provide contacts with social workers and local agencies concerned with social support. They may need to contact school administration officials or classroom teachers. Often there are informal networks or faith-based groups in a community that can be helpful.

TRAINING FOR CULTURAL COMPETENCE

Recommendations

Training for cultural competence is not a static concept, but an area of shifting demands that requires ongoing attention; the situations of communities and individuals can change rapidly. The concept of “cultural competence” should include language ability, familiarity with cultural customs and history, careful attention to social issues, and an ability to approach different cultures with respect, humility and empathy.

Professionals providing care for people in minority groups who do not share their language should work with interpreters specially trained in mental health issues, and culture brokers who can provide guidance on community issues. They should investigate the use of videoconferencing when an interpreter is not available locally.

Develop training courses for the workforce according to the community to be served, and give special attention to training for the workforce serving multicultural areas. Include evaluation of program design and effectiveness.

Recruit more people from minority backgrounds to enter professional training.

“Cultural competence” is rarely defined from the viewpoint of the minority community being offered medical services. It does not have a fixed definition; it differs according to the needs of specific communities, and incorporates a majority population’s viewpoint of a minority’s situation. Despite the variability of the definition, however, it has the important goal of improving understanding. At a minimum it requires self-awareness by service providers about their personal attitudes, in-depth knowledge of a community’s history as well as its current problems, and a sympathetic ability to communicate.

Professional Training

Medical school curricula should give expanded training for the issues that practitioners will encounter in serving diverse populations. Many medical schools offer only short modules on the subject, if it is addressed at all. Yet professionals in mental health fields encounter a range of complicated questions related to culture when trying to help patients. As mental health care becomes integrated into primary care, more doctors with a general medical background have to address such questions. The individual background, community customs and current social circumstances of racial minorities, indigenous people, immigrants, refugees and asylum seekers need to be taken into consideration. General practice doctors should be aware of the traditions of people from minority communities, and the ways in which they present mental distress.

Training on cultural issues should also be included in nursing and social work courses at all levels. Attention should be paid to expanding training opportunities through university or college certificate courses, or online delivery of course work. The effectiveness of training programs should be subject to evaluation.³⁰

Many more people from minority backgrounds should be recruited for medical training, research, nursing and social work. Facility in a second language should be prized.

Workforce Training for Primary Care

All levels of staff involved in providing integrated general health and mental health care to minority populations should have regular training on cultural issues as seen by the community they serve. This should be reinforced by a continuing process of in-service review and self-examination of attitudes. Could the health care staff (including doctors) be perceived as arrogant? Does the client feel welcome in the clinic or doctor's office? Are there long waiting periods? Do patients fail to come back for follow-up appointments? Can some of the staff communicate in the language(s) of the local community? Are members of the community employed in the office? What translation and interpretation services are available? Is printed material for mental health education available in the relevant language(s)?^{31 32 33}

Following widespread publicity about problems in the provision of mental health services for minority communities, improving access through primary care became a higher priority in England, as did workforce training in cultural competence, and the recruitment of black and minority ethnic workers. A 2003 Consultation Document from the Department of Health presented the following key actions: making the workforce representative of the community it serves; assessing individual and organizational learning/development needs; and providing staff with training on the legal requirements for racial equality.³⁴ The document also recommended, as a priority, extensive training to enable staff to collect better data about black and minority ethnic service users in order to make better planning decisions.³⁵ To improve career development, it supported a national leadership development program for black and minority ethnic staff.³⁶

LANGUAGE CAPACITY

It is critical for health care workers to be able to communicate in the language of the person seeking care if that person does not speak the health care worker's language, or has only a limited command of it. When there are language barriers, doctors and other professionals need to work with translators and interpreters to communicate effectively with people in distress, and their families or caregivers. To do so they need special training in how to work with interpreters, and the interpreters themselves should have special training about mental illness so that there is an effective collaboration. Translators can provide basic assistance with language, but interpreters should be able to offer additional skills. In addition to knowledge about mental illness they should provide insight into an individual's problems and the cultural expression of them.³⁷

Culture brokers and key informants, people with broad knowledge about the person's community, can also provide valuable guidance. They are knowledgeable about cultural matters, community affairs and leadership, and the type of help available within the community—including the use of faith healers (who may already be involved in the person's

care). Informal care in the community can provide a valuable support and should be recognized.³⁸

If mental health care is delivered in a relatively homogeneous minority community, the provision of language interpretation services is simpler than the language requirements of a multicultural urban area. Many urban areas need services for multiple minority communities, each with their own language and customs. Professionals should have contact with a range of interpreters for the language needs they encounter most. In some situations, translation through new technologies can fill difficult gaps.

In addition to providing language translation services for those with mental health problems, primary care providers need to consider the special communication needs of hearing-impaired people, including sign-language translation, and of people with poor vision who cannot read educational material.

Mental health professionals need to find an effective way to engage with people from minorities not only for making a diagnosis, but also to understand how they view their condition or problem. The World Health Organization and the World Organization of Family Doctors suggest that the following questions could help health workers to see disorders from their patients' point of view and "create an atmosphere in which they feel heard and accepted":

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your problem does to you? What are the main problems it has caused for you?
- How severe is your problem? What do you fear most about it?
- What kind of treatment/help do you think you should receive?
- Within your own culture how would you be treated?
- Is your community helping you with your problem? How?
- What have you been doing so far for your problem?
- What are the most important results you hope to get from treatment?³⁹

Complexity Beyond Language

Even when immigrants are native English speakers the complexity of the immigrant experience, shared between two or more cultures over time, should be taken into account. Immigration from the Caribbean islands provides an example. There has been a large movement of people from the Caribbean to Canada, the United Kingdom and the United States. Many maintain strong links to their island of origin. Their culture has absorbed a long experience of slavery, and they are accustomed to switch as needed between the historically-dominant white culture of the islands and the parallel African-Caribbean culture. When they become immigrants they have the stress of moving from a black-majority setting to minority status. Young second-generation immigrants can show alienation from both the culture of their parents and of their new countries, feeling they fit into neither.

Making Use of Technology for Translation

Mental health professionals working in indigenous or immigrant communities should have interpreters and cultural brokers experienced with these communities. Sometimes, however, they may have to provide services when no interpreter is available. On those occasions modern technology can be helpful. Now that telemedicine is becoming more widespread, language services are available in telehealth services. Real-time interactive videoconferencing can link a professional, a patient and an interpreter for an individual consultation.

As an example, in California many migrant farm workers come from the Mexican state of Oaxaca and speak the Mixteco language, with little or no Spanish or English. A Californian provider of mental health services has tried to overcome the language barrier by collaborating with the mobile telehealth service in Oaxaca. The telehealth link enables community health workers in Mexico to see the farm workers, speak with them in Mixteco, provide translation for the Californian provider, and give an initial opinion about issues. Both sides are trying to refine the system. Meanwhile, when the telehealth link is not in use by professionals, the California provider can make it available to migrant farm workers to enable them to see and speak to family members, considering it a simple form of mental health promotion.

Secure telehealth connections are coming into more widespread use to bridge geographical distance for indigenous communities and other people living in remote locations. While this can improve access to services, particularly for specialist care, the same need for a careful approach to local acceptability is required as for other projects. In an isolated setting technology may carry the risk of seeming to be imposed from “outside” unless a sensitive partnership with the local community is cultivated about its use. Funding agencies, technology providers, professional healthcare staff and local people may have very different views about how to use a telehealth network.

SPECIAL ATTENTION FOR CHILDREN AND ADOLESCENTS

Recommendations

Bearing in mind the age pattern of many mental disorders, health care providers in disadvantaged communities should provide mental health services for children and adolescents, with planning for consultation and referral to specialists in child and adolescent mental health.

Where possible, schools should be used as an important contact point for services, and for providing information about mental disorders to children, adolescents, their families and teachers.

Preventing students from dropping out of school should have high priority. Adolescent school drop-outs face mental health consequences.

Adequate services should be provided for children and adolescents from racial and ethnic groups. Disparities in mental health services are particularly acute in this area. Often children's services are not sufficient for the needs of the general population, let alone minorities. There are long waits for access if services are available at all. Health care planning should target expanding and improving mental health services for all children, and incorporate special provision for children from minorities. Primary care offices, pediatricians and schools can provide entry points for specialist services.

As with adults, services for children and adolescents from minority groups must be culturally appropriate. There is often a need for outreach to let families know how to recognize mental and behavioral problems and how to access help. Professionals should be knowledgeable about how assessment and diagnosis can be affected by an ethnic or racial community's culture. Special efforts may be required for engagement with the families of children needing care, and extra time may be needed for staff training. A high number of adolescents entering mental health care involuntarily, through referral by the juvenile justice system, should be a signal to policy-makers of unmet need.⁴⁰

Early attention to a child's problems can help to minimize future difficulties. Schools can be the setting for many issues involving children from racial and ethnic groups, and their families. Mental health professionals should develop closer links with education departments and school administrators to provide a gateway to services for individual children and their families. School administrators could use benchmarks like inability to read at age eight as a trigger for screening to investigate health and social conditions that affect the child's situation, in order to coordinate with appropriate services. This preventive measure could reduce behavioral and mental problems at a later age. In addition to linking individual students with mental health care providers, schools can introduce programs for social and emotional learning that provide age-specific strategies to encourage strengths and reduce classroom behavioral problems.

“At risk” children should be identified and appropriate services made available as needed. Children as well as adults are affected by poverty, and a family's social circumstances (unemployment, poor housing, etc.) should be considered when providing mental health care.

When necessary, involving a social worker and contacting other appropriate agencies should be part of the approach. Special circumstances can have a major impact and mental health professionals need to be aware of the wide range of background issues that can affect an individual child's wellbeing. This is especially the case if the family has experienced war or forced relocation overseas. Refugee families and their children who have experienced trauma may need services from professionals with special training.

Like all children and adolescents, a child or adolescent from a racial/ethnic family can be affected by separation from a parent, a situation that is not uncommon. Appropriate mental health services and support should be available if needed. Parents divorce or separate. Children are affected when a parent serves a prison sentence. Children are placed in foster care because authorities consider their wellbeing to be at stake, and yet separation from their parents can be hard for them to understand and accept. They are exposed to great anxiety about their future. Court appearances, if required, can produce additional stress on children and adolescents.

Other separation issues in immigrant families may be less obvious. Some families from Hong Kong maintain business interests there, resulting in a parent spending long periods away. Families from the Philippines often experience long separations when a parent accepts a job in Canada or the United States under immigration programs that delay the family from following for a year or more.

Though many children from indigenous, immigrant and refugee families show a remarkable capacity for adjustment, some can experience stress from having to absorb both family customs and those of the "outside" society, and may need help from culturally well-informed service providers. The children's capacity for adjustment in a bilingual setting may itself be a source of stress for parents who want to maintain a traditional family environment and may have less command of the second language. Tension is often seen between the generations as adolescents become more independent.

Focus on Youth

Special attention should be focused on teenagers and young adults. These are the years in which many mental illnesses and substance abuse problems become visible. It follows from an awareness of the age patterns of mental illness that adequate services should be available for young people. Instead there is a widespread shortage of mental health services for this age group. Primary care providers in disadvantaged communities should plan to make special provision for young people, and maintain links for referrals to specialists with experience in adolescent mental health.

Well-designed, culturally appropriate education campaigns about mental disorders that affect adolescents should be widely available and ongoing in disadvantaged communities. Information should be provided to parents and young people about the age patterns of mental illness, the possibilities for early intervention, the location of places where youth-oriented treatment is provided, and the prospects for recovery. The aim of such public education efforts is not only to help individuals, but to reduce the pervasive stigma that often prevents people from seeking treatment.

Schools can take a leading role in educating young adolescents about wellness and social and emotional health, about how to recognize serious mental health problems, and about the consequences of drug and alcohol abuse. There is a considerable body of research on the value of school programs to increase empathy and reduce bullying and violence.

Interest is growing in providing mental health and wellness information to young people through the Internet, as they use it as a normal mode of communication. While schools are an obvious channel for reaching young people, the Internet can be a useful additional tool for outreach, especially to those who have left school and those beyond normal school age.

Collaboration with educators should give a high priority to preventing students from dropping out of school. “Drop-outs” are at risk of getting into trouble with the law, and their future employment prospects are severely damaged. In addition to efforts involving parents and teachers, approaches could incorporate after-school programs for sports, recreation and coaching with class work.

A Youth Project from Jamaica

CARIMENSA, the Caribbean Institute of Mental Health and Substance Abuse, believes that young people’s mental health problems in Jamaica are linked to high unemployment and the lack of future prospects. It has proposed a national “Youth Rescue” project that would bring together many agencies to address youth problems in a comprehensive manner. The overarching goal is to address social and educational issues through long-term planning, in order to prepare young people for employment.

At the center of the plan is a proposed National Youth Rescue Monitoring Unit which would identify high-risk youth at an early age for special attention, and co-ordinate the activities of many agencies to improve the economic prospects of “at risk” children and young people. Educational institutions at all levels would be engaged in the collaboration, including those for teacher training. The Carimensa Institute for Cultural Therapy would also have a role. Special programs would be provided at age-appropriate levels. These would range from parenting programs for families with children under the age of three; family life education for people with children aged 4 to 5; remedial reading for children aged 6 to 10; and behavior modification and socialization for those aged 11 to 14. New technical training institutes would be established for those aged 15 to 25 to provide preparation for jobs requiring computer skills.

In view of Jamaica’s high unemployment rate, this plan recognizes that many people migrate to Canada, the United Kingdom and the United States to find work, and includes migration as one part of the nation’s employment options.⁴¹

RESEARCH ISSUES

“Until lions have their own historian, tales of the hunt will always glorify the hunter.”

- African proverb

Recommendations

Make a systematic effort to encourage minority participation in research, with special attention to the increased cost and time entailed in such efforts. Minorities and immigrants should be included in clinical and behavioral research, and research on mental health promotion and mental disorder prevention, in order to expand the evidence base. Minority communities should be cultivated to win their interest in research.

Minorities should be consulted in the development of research programs. Their viewpoints should be respected and incorporated, possibly by combining qualitative and quantitative research.

Children and young people from racial and ethnic minorities should be included in research on child and adolescent mental health, since many mental and behavioral disorders are diagnosed at an early age.

Disparities in care include a widespread failure to include minorities adequately in biomedical research. When they are not included in clinical trials, information cannot be developed about whether treatments are appropriate for them. The Supplement on Culture, Race and Ethnicity (2001) to the United States Surgeon General’s Report on Mental Health contained an appendix that detailed how minorities were seriously under-represented in the development of guidelines for the treatment of bipolar disorder, major depression, schizophrenia and attention deficit hyperactivity disorder. It also noted there has been no analysis to determine if outcomes for minority participants differ from those for the majority.⁴²

The February 2009 issue of *World Psychiatry* reviewed the intrinsic difficulties of carrying out trials for psychotropic drugs, problems in trial design, and the debate over the value of different kinds of trial.⁴³ It compared randomized controlled efficacy trials that have carefully selected patient groups, and broader effectiveness trials that are less rigorous about selecting participants and focus on the usefulness of medications in real practice situations. Noting discrepancies among results from different trials, one article commented: “Patient selection has been identified as one of the main culprits for discrepant findings.”⁴⁴ Results from trials where the participants are selected by narrow criteria do not provide an adequate match for the patients who would be seen in general practice. But alternatively, a large group of less highly selected patients could be expected to show more variability in results. The survey also discusses how drop-out rates adversely affect results, and sometimes reflect the design of the trial.⁴⁵

The recent EDICT report (Eliminating Disparities in Clinical Trials, 2008) by the Chronic Disease Prevention and Control Center at Baylor College of Medicine, in collaboration with the Intercultural Cancer Council, found that the exclusion of minority populations from clinical trials

in the United States was a general problem affecting the study of many illnesses, not just mental health. Women are also under-represented, as well as older adults and residents of rural areas. The study noted that in view of advances in genetic research, the failure to study genetic variations in racial and ethnic minorities will exclude these populations from new understanding of illnesses and treatments.⁴⁶

The EDICT study found that in general medical research there are many obstacles to including minorities in clinical trials, and that Federal and corporate research sponsors have made little progress in overcoming them. Although the NIH Revitalization Act of 1993 requires the inclusion of women and minorities in Federally-funded clinical research, government guidelines have “not translated into measurable improvements.” Among the many problems outlined in the study are the systematic exclusion of people who do not speak English well; the use of long, complicated consent forms in English with no translation; and the lack of clear information about insurance coverage for routine costs of care while participating in a trial. The EDICT team recommends making regulatory changes to produce a consistent Federal government policy on the inclusion of minorities, and, as almost 75% of funding for clinical trials comes from industry sponsors, “creating new regulatory incentives for pharmaceutical industry trials to include underrepresented populations, as well as imposing penalties for non-compliance with federal policy on appropriate inclusion.”⁴⁷

To increase minority participation in this complex world of clinical trials is no easy task, and yet it is necessary in order to explore the effectiveness of drug therapies for national populations that now contain high numbers of minorities, sub-divided into many racial and ethnic groups. The WFMH Experts Forum in Minneapolis discussed the issue and emphasized the importance of community involvement as a way of developing minority participation. It proposed a broad approach to research among these populations on treatments for mental illnesses, including a realistic appraisal of why this work is difficult. Behavioral research that respects culture and history should inform clinical investigation and play a role in developing a new approach to overcoming barriers. Studies should take into account the differences among minorities and also within members of a particular minority group in different settings. Data should be collected on the prevalence of mental illness in a community, but also on attitudes towards mental health. In addition to investigation of variability in a community’s response to drug treatments, mental health care can be improved by information about local beliefs concerning illness and health, and social requirements in delivery of services. Investigation should go beyond research on drugs and could, for example, show the value of including local healing practices in planning for care.

Why Are Minority Communities Reluctant to Participate in Research?

The framework in which research is conducted has inadequate outreach to hard-to-reach groups. Very few people from minorities have entered the fields of medical and behavioral research. Investigations usually have to be completed within the timeframe of a grant or contract, and this pressure makes it difficult to develop long-term relationships and study background issues that affect the way a project is conducted. Researchers often find it very difficult to prepare a project adequately when operating against a tight deadline. They are unwilling to seek out minorities that require special attention and will slow down progress. Communities can be hostile to outside investigations, or simply disengaged, feeling that the research is of no particular benefit

to them. Sometimes this is reinforced by previous research efforts that created a bad impression through lack of sensitivity and a short-term focus.

Because of past history, racial and ethnic minorities may feel that mental health interventions and treatments proposed by professionals and researchers reflect Western superiority and place the target group in an inferior role. Many indigenous and immigrant communities have their own approaches to healing that incorporate traditional or spiritual beliefs which they feel are ignored or viewed as “backward.” Indigenous peoples want to protect their cultures. Many immigrants also have strong cultural traditions and come from countries where they are a majority, not a minority. To be designated as a “minority” can carry its own stigma; there is a question of status involved.

Men of color may have a variety of reasons to be wary of mental health services, and consequently of mental health research, because of perceived prejudice. A study in the United States reported that these men tend to delay seeking treatment, viewing this as a sign of personal weakness, and when they eventually seek care they present with more serious problems. They are then likely to receive biased treatment, with a significant level of misdiagnosis and/or overmedication, and higher rates of involuntary inpatient care. This results in reinforcement of the tendency to delay seeking treatment, with a dread of involuntary commitment playing a major role.⁴⁸

Similar problems have been reported in the United Kingdom. There has been considerable criticism of the provision of mental health services to Black and minority ethnic communities (BME groups, as they are known in the United Kingdom) since the death of an Afro-Caribbean man in a secure facility in 1998. The National Health Service was accused of racial prejudice in the delivery of services, and people from BME groups were said to delay seeking treatment until disorders had become severe. Eventually, after an official inquiry into the 1998 case, an action plan was introduced in 2005 called “Delivering Racial Equality in Mental Health Care.” Soon after implementation began it was faulted for insufficient attention to ethnic differences.⁴⁹ As part of the action plan, from 2005 an annual census of the ethnicity of inpatients is now taken (the “Count Me In” census). The 2008 census, like the earlier ones, showed that detention rates in mental health facilities were much higher for Afro-Caribbean people than the national average, and that Black people had higher seclusion rates than others. The census results from 2005 to 2008 indicated that the “Delivering Racial Equality” action plan had not produced expected improvements in care.⁵⁰

In certain groups a very high distrust of outsiders exists for historic as well as contemporary reasons. Specific communities have experienced slavery, persecution, genocide. The impact of the past is felt to the present day, and researchers should be prepared for anger and hostility arising from the lasting memory of these events. They need to acknowledge such sentiments, for which they may not have any direct responsibility themselves, as they develop relationships with affected communities.

Just as historically-defined concepts of superiority and inferiority permeate notions of mental health, poverty is often an underlying issue. Large numbers of people in minority groups live in marginal economic circumstances, and this reinforces the superior/inferior construct. Poverty

results in stress and discrimination; color prejudice is high; and there exists a widespread general bias against immigrants in many places, regardless of color. Acknowledgement of discrimination can create opportunities to examine issues of importance. Many people in disadvantaged circumstances experience casual prejudice in their everyday lives, inadvertent, subtle or open. The feelings of anger and resentment that researchers may encounter in their work with minorities need not necessarily be an obstacle. These feelings are real, and taking them into account can point the way to better investigation protocols and better outcomes for interventions.

The dynamic of superiority/inferiority is built into scientific research, which normally incorporates Western/White dominance in its concepts. Evidence-based best practices for mental health interventions and treatment are often (although not always) based on research in the Western countries where funding is available. Clinical or behavioral interventions that are firmly grounded in good evidence reflect specific countries, populations and settings, and are not necessarily suited to racial, ethnic, indigenous or immigrant communities. Research should include people whose culture differs from that of the majority so that their needs can be met.

Research Abroad

The attitudes that hamper the inclusion of representative samples of the domestic population in clinical trials can also extend to research abroad. A perception of discrimination can arise when a research trial is undertaken in a less developed country in order to meet particular requirements for a study, or to obtain a more relaxed regulatory environment. A participant in the WFMH Forum said that such trials often employ well qualified local professionals but pay them at a much lower rate. They can also sometimes impose their research models without adequate local consultation, engaging in a form of “academic imperialism.”

The Space In-between

In order to increase participation in clinical and behavioral research trials, new efforts at outreach should focus on educating minorities about the value of research to the health of their communities. Given the current barriers to their participation, this is likely to be a slow process requiring the tailoring of specialized information for many different groups and sub-groups, with careful attention to language and cultural issues.

From the viewpoint of minorities, barriers to participating in research trials may include not only a fear of mental health services, but a lack of familiarity with the entire world of medical and social investigation, academic standards and evidence-driven policy development. These highly specialized activities can seem unconnected to their daily environments. It is relevant, for example, that Native American tribal groups do not have a tradition of measurement comparable to that used in Western research. They respect what works, according to their own practices and knowledge, and have little interest in validating it through research trials. Measurement may be resented as a challenge to established tribal customs. From this viewpoint there is little interest in evidence-based practice derived from “outside” values.

Looking for “the space in between the parties” in this difficult situation can help to overcome communication problems between researchers and disadvantaged communities, allowing them to move into a more collaborative relationship. The essence of the concept is to acknowledge past and current problems, and encourage a dialogue with an open exchange of views that can pave the way for a change of attitude on both sides. A “neutral” meeting where each side comes as an equal can permit past experience of adversity and mistreatment to be openly acknowledged, and show that traditional and spiritual values are respected. Each side should contribute to a fresh approach.

Though it is not easy, progress can be made in overcoming barriers through a careful, long-term engagement with the partner community. *Listening respectfully is important.* With a slow approach that emphasizes consultation, contacts can be developed with a broad group of leaders—people with status for political or spiritual reasons, and also teachers and others in the community who are well informed, respected, and in touch with local opinion. In tribal groups there may be a defined process which must be respected about approaching tribal elders. Finding the right people to work with is a key part of the effort.

Those involved in a sensitive participatory research process will discuss the goals of their project clearly. As an integral part of the process researchers should see if issues other than their own are of concern in the community or of interest to its members, and incorporate that input into the overall research agenda. Community leaders and other representatives can be asked to review the research agenda to say if some items are inappropriate, and invited to add to the list. By changing parts of the agenda as a result of local input, the researcher gives up some of his/her control but the community has increased ownership of the project. It can be argued that such an intense extra involvement affects objectivity, but the results may justify it. If the research process grows out of the community as well as from the outside investigators, ongoing local engagement can be established more easily.

A collaborative approach respecting local values and interests could result in hybrid forms of research that combine social and clinical areas of work, or qualitative and quantitative investigations. Qualitative research might provide a new understanding of the local situation that illuminates other results, showing what evidence the community values and what it considers to be a “good result.”

As part of the process of interesting a community in research, those engaged in it should support general education about mental health, framed in a culturally appropriate manner (perhaps in concert with primary care staff in the area, or school administrators). This information is an essential basis for local engagement in the research effort.

Investing in preliminary work comes at a price. It can ensure the success of a research project—and add greatly to its expense and the time needed. *Project planning for work with ethnic and immigrant groups should ideally incorporate an extended timeline and appropriate costs, in order to allow researchers to become well acquainted with issues that are unfamiliar to them and to establish good relations with the people with whom they wish to work.* In addition to careful preparation at the start of a project, at the end of it the results should be communicated to the participating group, so that they can support recommendations and potentially benefit from

results. In some cases outcome information can be presented in a way that allows the group to take follow-up action itself, such as asking for better services or applying for a grant to introduce them.

The best research results will be obtained by forming an empathetic connection with the community, and (as with cultural competence in healthcare practice) approaching its members with humility and respect.

Working with Ethics Committees for Research Approval

It can be argued that an Ethics or Research Committee should have representation from the local community where the research will be conducted, but this is unlikely to be the case. It is normal for research done through universities and medical institutions to be approved by Ethics Committees of academics, bioethicists and lawyers. They may be unaware of the under-representation of certain groups in research trials, and its history. They may view a focus on specific ethnic or racial groups as “racist” or prone to bias. They may know little about differences among various minority groups in metabolic responses to pharmaceuticals. They may be unfamiliar with the special challenges for clinical trials or behavioral research in reaching vulnerable communities. Researchers need to present a strong case for the value of work with minority groups, the reasons for neglect in the past, and the ways obstacles can be overcome.

Data Collection—“No Outcome, No Income”

Data on mental health outcomes reveal disparities in care, place a spotlight on areas in need of research, and can be an effective driver of policy. Stronger data collection will help policy development. In many places, however, records are kept on paper and information is difficult to consolidate. Electronic data collection by health care offices should, over time, produce valuable information but will also raise privacy concerns that must be addressed.

Often when data are collected, ethnic or immigrant groups are described in very broad categories that reflect their composition in basic ways only. For example, “Asian” is a category that is frequently used, yet it covers people from many countries with widely different backgrounds. When a statistical breakdown includes only that category much relevant information is lost. Research involving groups and sub-groups should collect and analyze statistics for sub-groups systematically, as well as present them in an “umbrella” category.

Special Considerations for Research Involving Children

More research is needed on mental health issues affecting children and youth from minority backgrounds, and on approaches that lead to effective treatment and/or behavioral interventions. This a very difficult field in which to collect evidence. Researchers working with children from racial, ethnic or immigrant groups must consider the special complications that are involved in trying to assess their development and behavior. Their experiences and those of their families may differ substantially from those of the mainstream population, from other racial or ethnic groups, and even from other sub-groups of their own nationality or community. Where another

language is involved, difficulties in interpreting words and concepts can easily arise. Problems of interpretation and comparison of concepts are multiplied if the project involves children from a number of different immigrant groups; very careful consultation is needed to find agreed interpretations.

There are many gaps in research on the provision of culturally-competent mental health services for children and youth from minority communities. A 2006 study published by the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida examined the research base in the United States for this subject, and identified only a small group of relevant reports. In the initial search 1,313 articles were identified that met the study's parameters (articles published in the United States from 1994 to 2004 and based on research or a literature review). Of these, 274 articles were found relevant to the study and received a full-text review and content analysis.⁵¹ The reviewers found 31 articles that focused on African American populations, of which 23 focused on children, adolescents and families, and 8 focused on African American populations of all ages, including children and adolescents.⁵² There were 29 articles on Latino child and adolescent mental health. Most of the articles failed to report details such as country of origin of the people in the sample or their level of English language ability.⁵³ Fourteen research articles that included children and adolescents were found for Asian and Pacific Islander populations. Of these 7 focused on Asian and Pacific Islander populations alone while the others included other racial and ethnic groups.⁵⁴ Where other groups were included, the origins of the Asian/Pacific Islander sample were not clearly identified. There were only 10 research articles relevant to Native American children and adolescents.⁵⁵

In recommending directions for further research, the FMHI study identified a need for more attention to different developmental stages, with a focus on early childhood and middle childhood as well as adolescence. It also pointed to “a clear need for identification of within-group differences by factors such as country of origin, immigration or refugee experiences, gender, tribal affiliation and community of residence within the United States.”⁵⁶ It recommended studying particular racial/ethnic populations in various geographic locations to enhance the understanding of within-group variations. An expanded evidence base on parents' views of their child's symptoms, their help-seeking behavior, parents' and children's preferences for treatment, and barriers to accessing services could help in the development of early interventions and improved care.⁵⁷

Like the FMHI study, a new report from the U.S. National Research Council and the Institute of Medicine on “Preventing Mental, Emotional, and Behavioral Disorders Among Young People” highlights the importance of a developmental perspective for research on the mental health of children, adolescents and young adults. It stresses that valuable opportunities to prevent disorders arise through interventions at an early age, since half of all mental, emotional, and behavioral disorders among adults are diagnosed by age 14, and three-fourths by age 24.⁵⁸

PROMOTING MENTAL HEALTH AND PREVENTING THE EMERGENCE OF DISORDERS

Recommendations

The relevance of evidence-based mental health promotion initiatives and mental disorder prevention programs to minority groups should be carefully reviewed by government agencies. Where evidence-based programs are unsuited to the local circumstances of minority populations, consider the value of rigorously reviewed practice-based and community-based mental health programs for specific local needs. Encourage the development of appropriate evidence.

Foster collaboration on mental health promotion and the prevention of disorders between the education sector and researchers working on child and adolescent mental health.

Consider including the arts valued in minority cultures in mental health promotion activities for them.

At the WFMH Forum there was a considerable emphasis on the importance of mental health promotion for minorities and on making available interventions for the prevention of disorders. These two areas are closely linked and they exist at several levels. Evidence-based programs for the promotion of mental health and for the prevention of mental disorders are the “gold standard.” They are the result of extensive research and evaluation, and have been shown in a measurable way to promote mental health and/or reduce the prevalence of mental disorders. There is also considerable evidence available on effective interventions to limit certain disorders as they emerge. In addition, there are many community- or practice-based programs that have been designed at a local level to suit specific needs. These benefit from local experience and acceptability.

Prevention of mental disorders. Much of the evidence base on the prevention of mental disorders has been developed in majority communities,⁵⁹ with only a limited application to racial and indigenous minorities. Racial, ethnic, immigrant and refugee communities have generally been neglected. As the field moves from research toward more widespread implementation, it is important to include a broad representation of minorities in the expanding effort. The 2009 Report on “Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities” includes among its recommendations to policy-makers “*Adaptation of research-based programs to cultural, linguistic and socioeconomic subgroups.*”⁶⁰ The report also urges researchers and communities to join in evaluating prevention interventions that have originated in communities and been shown to be well accepted by them.⁶¹

Evidence-based interventions can be measurably shown to prevent disorders. They cover many situations. Interventions have been developed that focus on training in parenting skills for young mothers from disadvantaged communities, and on strengthening early childhood development. A widely adopted program for the children of parents who have mental disorders is designed to support the children’s mental health and improve family functioning. There are many school-based programs that teach social skills and emotional control appropriate to various age levels. Measures to promote good behavior by children in the early school years, including training

teachers in classroom management, have been shown to improve general academic performance and mental wellbeing at much later stages in school. Other interventions aim to reduce school bullying and violence.

Such programs could be adapted to serve diverse communities but need to be adjusted to reflect cultural and language requirements, and carefully re-evaluated for effectiveness and fidelity to the original research. The American Indian Life Skills initiative provides an example of how an evidence-based approach can respond to specific community concerns while also introducing general prevention concepts. The project investigator was asked to address suicide prevention among high school students in a Zuni pueblo, and sought detailed information from tribal representatives about customs and beliefs. The initiative incorporated tribal views on behavior and celebration of life, together with problem solving, communication skills, depression management, stress management and anger regulation. All of the program content was set in the context of everyday tribal life. The initiative was later reviewed and adjusted to serve some other American Indian tribes, and is being evaluated for American Indian youth in urban schools.⁶²

Mental health promotion. Mental health promotion initiatives address both wellness and mental illness. They recognize the link between social settings and mental health. Evidence-based interventions are available that have been shown to strengthen skills and resilience, and modify risks. They are designed to promote positive mental health and can address many other issues. Programs can be used in various settings to increase public understanding of mental disorders, reduce stigma and educate people that treatment is available.⁶³ Quite often, however, small programs are designed in individual communities to meet local needs and are not subject to extensive evaluation of effectiveness because of the additional cost. More research is needed to find the best approaches that originate from these local initiatives and incorporate them into larger mental health strategies.

At a general level it is possible to address mental health promotion for diverse populations. This is the goal of the World Federation for Mental Health's global World Mental Health Day campaign, launched each year on 10 October, which provides information on a selected topic for use in public outreach. The Federation prepares material and arranges for translation into a growing number of languages, but relies on local contacts around the world to adapt it to suit their individual situations. The participating organizations and agencies take the topic and publicize it for their own populations according to their circumstances, culture and available funds. This strategy results in multiple and varied community-based initiatives which have the common goal of increasing public education about mental health. In 2007 the World Federation for Mental Health featured "The Impact of Culture and Diversity" as the campaign topic, to highlight the growing need to provide for diverse groups in mental health care. The following year's topic was the value of citizen advocacy and action on mental health issues, and the 2009 campaign focuses on the provision of mental health care in primary care.⁶⁴

Mental health promotion, if loosely defined, can address obvious needs while not directly focusing on mental health. As an example, language and literacy classes are valuable for immigrants with a poor educational background, especially women. The classes can improve their ability to cope with daily living, take care of their families and communicate with their

children's schools. At the other end of the educational spectrum, not enough attention is paid to the problems of men and women who come to a new country with qualifications that are not easily transferable. Programs should be developed for this neglected area to try to provide information and support that would help these people to deal with a depressing situation. Such efforts can address important mental health needs. Typically, there is no additional staff and money to measure results.

The concepts of mental health promotion and disorder prevention should be the concern of multiple government agencies, but it has proved difficult in practice to develop shared approaches. Education, housing and juvenile justice should be included as natural partners, but perhaps because the original initiatives come from a medical/mental health setting there is a problem in forming connections among different departments. The education sector is the partner most discussed in this report, and although some progress is being made it faces many administrative and financial obstacles in expanding school-based mental health initiatives.

Consider Including the Arts in Mental Health Promotion

The arts can play a role in mental health promotion. These activities can be effective methods of engagement, enjoyment and education. They provide recreation and can incorporate the customs of minority communities. Traditions can be a source of strength in a community, and outreach that values them and incorporates them into programs of support can be particularly effective. Training programs at various levels should give some creative attention to this. In Jamaica the Caribbean Institute for Mental Health and Substance Abuse (CARIMENSA) has formalized such efforts with an innovative graduate degree program that combines training in issues of community development with cultural therapy involving dance, music, arts and drama. In Australia the Victorian Health Foundation (VicHealth) has highlighted the value of ethnic festivals in promoting the mental health of Victoria's many immigrant communities.

A NEED FOR ADVOCACY

Recommendation

Expand the advocacy network as broadly as possible to address discrepancies in mental health care for minorities.

The participants in the International Experts Forum in Minneapolis stressed the importance of advocacy in drawing more attention to disparities in mental health care and in pressing for improvements. Although there are a number of national advocacy organizations for ethnic and racial groups, for many minorities it is very difficult to engage in advocacy on their own behalf locally or nationally. Often indigenous people live in geographic isolation. Refugees and asylum seekers have obvious difficulties in the resettlement process. Immigrants in general contend with multiple difficulties on arrival in a new country, and lack the time, language ability, interest and connections to take part in advocacy. There may have been no tradition of public discussion and organization around political and social issues in their former countries. And mental illness is an unpopular subject.

To further the recommendations in this report, the Forum participants supported the concept of advocacy coalitions composed of various groups concerned with disparities in mental health care. These should include as broad a representation as possible of the people affected, together with professionals engaged in mental health care, refugee resettlement agencies, representatives from government departments and local government agencies, school administrators, faith-based groups, mental health associations, and other concerned organizations. Although some minorities may find it difficult to take part in advocacy, other minority groups are well able to voice their concerns and needs and should be encouraged to grasp that opportunity.

In the United States a new advocacy coalition is emerging, the National Network to Eliminate Disparities in Behavioral Health (NNED, see appendix on page 40). Planning began in 2007 with support from the Substance Abuse and Mental Health Services Administration (SAMHSA). A network structure was selected so that “one unit is not merely the formal subordinate of others.”⁶⁵ Founding members are the National Alliance of Multi-Ethnic Behavioral Health Organizations and its four constituent organizations, the First Nations Behavioral Health Association, the National Latino Behavioral Health Association, the National Asian American Pacific Islander Mental Health Association, and the National Leadership Council on African American Behavioral Health.

The key focus is to develop and strengthen community- and ethnic-based organizations and networks, and to build community engagement.⁶⁶ At a different level, existing national organizations will participate in a National Facilitation Center, helping to guide the growth of the NNED.⁶⁷ One of the priority goals of the network is to increase trained minority participation in the behavioral health workforce.

The NNED initiative is an example of an approach that can produce informed advocacy. Other initiatives also can help communities to put forward their case locally, on their own behalf or as part of a coalition, or as members of a broader effort reaching to the national level. This will

often involve initial outreach to educate minorities about the unfairness of disparities in mental health care, and to teach them about advocacy. These twin goals will serve the purpose of improving public information in underserved communities and strengthening general advocacy. When minority communities are able to advocate for their own case and join as strong partners in wider coalitions, campaigns for improved mental health care will be invigorated. With effective advocacy they should be able to present their particular community needs and secure services that are suitable for local circumstances and beliefs.

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**APPENDIX: U.S. NATIONAL NETWORKS
TO ELIMINATE DISPARITIES
IN BEHAVIORAL HEALTH (NNED)**

**National Alliance of Multi-Ethnic Behavioral Health Associations
(NAMBHA)**

1875 I Street NW
Washington, DC 20006
Tel: 410 925 2210 or 202 806 4727
Email: misaacs5548@comcast.net
Web: www.naapimha.org

National Leadership Council on African American Behavioral Health, Inc.

111 South Highland, Suite 180
Memphis, TN 38111
Tel: 888 423 9622
Email: nlc_aabh@bellsouth.net
Web: www.nlcouncil.com

National Latino Behavioral Health Association

P.O. Box 387
506 Welsh Street, Unit B
Berthoud, CO 80513
Tel: 970 532 7210
Fax: 970 532 7209
Email: msanchez@nlbha.org
Web: www.nlbha.org

National Asian American Pacific Islander Mental Health Association

1215 19th Street, Suite A
Denver, CO 80202
Tel: 303 298 7910
Fax: 303 298 8081
Email: info@naapimha.org
Web: www.maapimha.org

First Nations Behavioral Health Association

Box 55127
Portland, OR 97238
Tel: 503 953 0237
Fax: 503 954 1741
Email: info@fnbha.org
Web: www.fnbha.org

APPENDIX: INTERNATIONAL SOURCES OF INFORMATION

Centre for Addictions and Mental Health

Toronto, Canada
1-416-535-8501
www.camh.net

Centre for Evidence in Ethnicity, Health, and Diversity

Warwick Medical School UK
<http://www2.warwick.ac.uk/fac/med/research/crsi/ethnicity/health/>

Diversity Health Institute

Locked Box 7118
Parramatta BC NSW 2150
Australia
www.dhi.gov.au

Mental Health America

Post Office Box 16810
Alexandria VA 22302-0810
www.mentalhealthamerica.net

Multicultural Mental Health Australia

Locked Box 7118
Parramatta BC NSW 2150
Australia
www.mmha.org.au

Victorian Health Promotion Foundation (VicHealth)

Ground Floor
15 – 31 Pelham Street
Carlton 3053
PO Box 154
Carlton South
3053 Australia
www.vichealth.vic.gov.au

WHO Pacific Islands Mental Health Network (PIMHNet)

Tel: +64 4 388 7379
Fax: +64 4 234 8689
Email: steph@wellpro.co.nz
Website: http://www.who.int/entity/mental_health/policy/pimhnet/en/

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