

# Introduction to the Special Issue on Culture and Community Mental Health

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Since 1980, the racial/ethnic diversity of the United States has rapidly increased. Also in this time, though the population of the United States has aged in general, the difference between the youngest and oldest age groups and their percentage of non-White population has widened (U.S. Census Bureau, 2002). From 1980 to 2000, the population of races other than White non-hispanic grew by 88% while the White non-hispanic population grew by 7.9%. By 2000, four states and the District of Columbia had minority populations in total exceeding 50% of the population.

Data on age by race and Hispanic origin reveals that throughout the period between 1980 and 2000 White non-Hispanics and Asian and Pacific Islanders were relatively older than Black Americans, American Indians and Alaska Natives, and Hispanic Americans. The median age for White non-Hispanics in 1980 was 31.7-years-old and in 2000 was

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38.6-years-old. For Asian and Pacific Islanders the median age in 1980 was 26.6-years-old while in 2000 it was 32.6-years-old. At these same two time points Black Americans (24.9 and 30.2 years, respectively), American Indians and Alaskan Natives (23.0 and 27.9 years, respectively), and Hispanic Americans (23.2 and 25.8 years, respectively) were younger than their White non-Hispanic and Asian and Pacific Islander counterparts. The most significant contributors to the rapid growth in the racial/ethnic diversity of the United States and the relative youth of Minority Americans have been increases in immigration into the United States as well as births to new immigrants.

With this increasing racial/ethnic diversity as well as the unique health related needs of specific immigrant groups for professional interpreters, mental health service systems, providers, and researchers have been challenged to develop and implement strategies to provide all racial/ethnic groups with timely, evidence-based, and cost-effective care. Unfortunately, the available evidence regarding the timeliness and quality of care to minorities compared to their White counterparts shows significant disparities in care. The supplement to the U.S. Surgeon Generals Report on Mental Health, "Mental Health: Culture, Race and Ethnicity" (U.S. D.H.H.S., 2001) detailed significant disparities in the access to and the quality of care for minority populations compared to their White American counterparts. Though lack of health insurance is the most significant contributor to racial/ethnic disparities in care, significant quality of care disparities continue to exist when racial/ethnic minorities are compared to White Americans with similar health insurance status. Members of minority groups who have mental illnesses have lower access than White Americans to ambulatory services, receive inappropriate diagnoses, and are offered newer pharmacotherapeutic treatments and/or psychotherapy less often. These racial/ethnic disparities in providing timely and effective care increases the mental health burden of disease within each minority group compared to White Americans. In addition, racial/ethnic disparities in timely and effective treatment contribute to the cost-ineffectiveness of mental health care, an issue of grave importance to payers of health care.

Because of the disturbing findings of racial/ethnic disparities in care and the ever-increasing population diversity within the United States, there is a pressing need to eliminate racial/ethnic disparities. The publication of the Department of Health and Human Services standards for Culturally and Linguistically Appropriate Health Care Services (CLAS) (U.S. D.H.H.S., 1999a) and Cultural Competence

Standards for Managed Mental Health Services for Underserved/Underrepresented Racial/Ethnic Groups (U.S. D.H.H.S., 1999b) are but two concrete examples of how important bridging cultural gaps in care are to payers of health care, policymakers, providers of care, and researchers. Subsequent to the publication of CLAS, the Institute of Medicine's report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare" (IOM, 2003) detailed the evidence for disparities in the quality of care within the operation of health care systems and the legal and regulatory climate in which health systems function; and within patient-provider interaction and treatment decision-making. These publications reflect the immediate and on-going need to change the environment within which health care is delivered as well as the processes involved in health care delivery.

Providing cost-effective and quality care to an increasingly diverse racial/ethnic population of patients is not a simple task. With the expanding cultural diversity comes the challenge of developing a trusting, working relationship between individuals (patients and providers) who may have different perspectives and views on what is mental illness and how best to treat it within the context of the patient's culture. Complicating this picture further is the paucity of intervention studies specifically identifying evidence-based treatments for non-White American racial/ethnic groups.

This special edition of the *Community Mental Health Journal* represents the efforts of the Board of the American Association of Community Psychiatrists (AACCP) to address problems that have at their root a lack of attention to the challenges that racial/ethnic diversity present to the practice of Community Psychiatry. The Board has recently approved a position statement, echoing themes in this introduction and in this special issue.

The articles chosen for this special edition serve to illustrate some of the complex factors involved in racial/ethnic disparities in care and the multiple levels of health system analysis that are needed to reduce if not eliminate racial/ethnic disparities in care. Two articles address system level issues in the child mental health and criminal justice systems while one brief report addresses differences in the types of services provided/accepted by different racial/ethnic groups within an adult community mental health system. Three articles address patient level issues such as medication adherence, help-seeking attitudes and behaviors, and the unique risk factors for mental illness and the mental health service needs for the United States' diverse immigrant populations. One article addresses the ethical issues and community based

perceptions of research that must be addressed to improve the recruitment and retention of racial/ethnic minorities in research studies. Last, we end this special edition with a real-world account of the complexity in providing cross cultural care; that being a third year psychiatry resident's experience in developing a collaborative relationship between a domestic violence shelter and a community mental health center to address the mental health needs of South Asian immigrants.

Though this issue is not intended to be a comprehensive look at all of the influences of culture on community psychiatry, we hope that this issue adds to the growing body of knowledge within the field of cross-cultural mental health services. We hope the articles provide useful information to health care administrators and providers that will support their efforts in providing quality care to all individuals regardless of their race or cultural background. Finally, we encourage other authors to share their unique perspectives on cultural aspects of Community Psychiatry in future issues of the Journal.

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