PREVENTION *Report*

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FOCUS

Culture Counts in Mental Health Services and Research

"The state of our knowledge about health and illness has never been greater. The best way to ensure an end to the disparities we have discovered is for everyone engaged in mental health services to make a steadfast commitment to accomplish the goal. It will take all of us."

Surgeon General David Satcher

America has come to mean diversity—in cultures, races, and ethnicities. Unfortunately, diversity currently also means striking disparities in access, quality, and availability of mental health services for racial and ethnic minority Americans, according to *Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General's Report* (http://www.surgeongeneral.gov/library/mentalhealth/cre/).

Culture, broadly defined as a common set of beliefs, norms, and values, influences many aspects of mental illness and mental health, including the types of stresses people confront, whether or not they seek help, what types of help they seek, what symptoms and concerns they bring to clinical attention, and what types of coping styles and social supports they possess. Likewise, the cultures of clinicians and service systems influence the nature of mental health services.

Two years ago the first Surgeon General's report on mental health acknowledged the existence of disparities, but the recent supplement stresses this message: "culture counts." Supporting information is presented on the four most recognized racial and ethnic minority groups in the United States: African Americans, American Indians and Alaska Natives (AI/AN), Asian Americans and Pacific Islanders (AA/PI), and Hispanic Americans. For example:

- African Americans represent 12 percent of the U.S. population—33.9 million people. They are overrepresented in high-need populations that are particularly at risk for mental illnesses, including homeless people, people who are incarcerated, and people exposed to violence.
- Approximately 4 percent of the U.S. population—over 11 million people—identify themselves as Asian Americans. Many Southeast Asian refugees are at risk for posttraumatic stress disorder associated with trauma experience before and after immigration to the United States. Nearly 1 out of 2 will have difficulty accessing mental health treatment because he or she does not speak English or cannot find services that meet his or her language needs.

- The rapidly growing Hispanic/Latino American population numbers more than 35.3 million people and by 2050 will increase to nearly one-fourth of the U.S. population. Studies have found that Latino youth experience proportionately more anxiety-related and delinquency problem behaviors, depression, and drug use than do non-Hispanic white youth.
- The Federal Government currently recognizes 561 different American Indian or Alaska Native tribes; many others are not officially recognized. The 4.1 million AI/ANs speak some 200 indigenous languages. Disparities exist on many measures: The suicide rate is 1.5 times the national rate. Approximately 101 AI/AN mental health professionals are available per 100,000 AI/ANs, compared to 173 per 1000,000 for whites. Only 50 percent of AI/ANs have employer-based insurance coverage, compared to 72 percent for whites.

Fact sheets on each of the four groups can be found at:

- African Americans (http://www.mentalhealth.org/cre/fact1.asp)
- Asian Americans/Pacific Islanders (http://www.mentalhealth.org/cre/fact2.asp)
- Latinos/Hispanic Americans (http://www.mentalhealth.org/cre/fact3.asp)
- Native American Indians (http://www.mentalhealth.org/cre/fact4.asp)

The report and the fact sheets represent information for each group in these categories:

- Need for mental health care
- High-need populations
- Availability of mental health services
- Access to mental health services
- Use of mental health services
- Appropriateness of mental health services

The contrasts across the groups by category are remarkable. AA/PIs appear to have extremely low use of mental health services compared to other population groups. While more research is needed, shame and stigma are believed to figure prominently in the lower rates. In terms of access to mental health services, Hispanics have the lowest rate of uninsurance (37 percent), compared to 16 percent for all Americans, 21 percent of AA/PIs, 24 percent of AI/ANs, and nearly 25 percent of African Americans.

Use of mental health services is also wide ranging: fewer than 1 in 11 Hispanic Americans with a mental disorder contacts mental health specialists. Representative community data have not been published for AI/ANs.

Although the four racial/ethnic minority groups are the focus of the supplement, the report points out that other populations encounter disparities in mental health services, including people who are gay, lesbian, bisexual, and transgender or people with co-occurring physical and mental illnesses.

Within each of the four groups addressed by the report are many distinct subgroups. For example, the Hispanic American group consists of subgroups including Cuban Americans and Puerto Rican Americans. Unfortunately, data limitations are noted within groups and subgroups. For example, because few data have been collected,

lack of understanding exists about why rates of co-occurring mental illness and substance abuse (especially alcohol) are higher among Native youth and adults than national rates.

Other examples of lack of data include the following:

- Few members of any racial and ethnic minority groups have been included in the clinical trials used to develop treatment guidelines for major medical and mental disorders.
- Utilization rates for alternative therapies are not known.
- The percentage of Spanish-speaking mental health professionals is not known.
- No large-scale epidemiologic studies of AI/ANs have been published.

Statistical data are not the only form of missing information. Because of stigma and shame associated with mental illness, some AA/PIs present with more severe illnesses than do other racial or ethnic groups. Mental illnesses may be undiagnosed or not treated early because they are expressed in symptoms of a physical nature.

Even when differences are noted, appropriate treatment does not necessarily follow. For example, even though data suggest that blacks may metabolize psychiatric medications more slowly than whites, blacks often receive higher dosages than do whites, leading to more severe side effects. As a result, they may stop taking medications at a greater rate than whites with similar diagnosis.

The status quo obviously has to change. The final chapter in the Surgeon General's *Supplement* highlights promising courses of action for reducing barriers and promoting equal access to quality mental health services for all people who need them. Thus, the vision for the future calls for these efforts:

1. Continue to expand the science base.
2. Improve access to treatment.
3. Reduce barriers to mental health care.
4. Improve quality of mental health services.
5. Support capacity development.
6. Promote mental health.

As U.S. Department of Health and Human Services (HHS) Secretary Tommy G. Thompson said in his opening message, “An exemplary feature of this *Supplement* is its consideration of the relevance of history and culture to our understanding of mental health, mental illness, and disparities in services. In particular, the national prevention agenda can be informed by understanding how the strengths of different groups' cultural and historical experiences might be drawn upon to help prevent the emergence of mental health problems or reduce the effects of mental illness when it strikes. This *Supplement* takes a promising first step in this direction."

He concludes, “Together, we can develop a shared vision of equal access to effective mental health services, identify the opportunities and incentives for collaborative problem solving, and then seize them. From a commitment to health and mental health for all Americans, communities will benefit. States will benefit. The Nation will benefit.”

SPECIAL FEATURES

Mental Health and the Federal Government

Every agency within the U.S. Department of Health and Human Services (HHS) and many other Federal agencies are involved in some way with mental health, whether in the delivery of services, research, education and training, or information dissemination. Recently, with the September 11 attack on America, many agencies and private sector organizations are providing mental health-related resources and information. (See *Mental Health Groups Take on Terrorism*.)

Within HHS, two agencies have principal responsibility for mental health: the National Institute of Mental Health (NIMH) (http://www.nimh.nih.gov) within the National Institutes of Health (NIH) and the Center for Mental Health Services (CMHS) (http://www.samhsa.gov/centers/cmhs/cmhs.html) within the Substance Abuse and Mental Health Services Administration (SAMHSA). NIH and SAMHSA served as co-lead agencies for the *Healthy People 2010* Focus Area 18. Mental Health and Mental Disorders. (See *Healthy People 2010: Mental Health and Mental Disorders*.) Both NIMH and CMHS have played key roles in the recent U.S. Surgeon General's publications related to mental health. (See *Culture Counts in Mental Health Services and Research* and *Children's Mental Health: A National Priority*.)

National Institute of Mental Health

NIMH's stated mission is **to reduce the burden of mental illness through research on mind, brain, and behavior**. The institute carries out this mission in the following ways:

- Conducts research on mental disorders and the underlying basic science of brain and behavior.
- Supports research on these topics at universities and hospitals around the United States.
- Collects, analyzes, and disseminates information on the causes, occurrence, and treatment of mental illnesses.
- Supports the training of more than 1,000 scientists to carry out basic and clinical research.
- Communicates information to scientists, the public, the news media, and primary care and mental health professionals about mental illnesses, the brain, mental health, and research in these areas.

NIMH's strategic plan, "Pathways to Health: Charting the Science of Brain, Mind, and Behavior" (http://www.nimh.nih.gov/strategic/strategicplanmenu.cfm), sets forth and describes these goals and related research priorities:

- Goal 1: Understand mental illness and mental health.
- Goal 2: Understand how to treat and prevent mental illness.
- Goal 3: Strengthen the mental health research platform.

Center for Mental Health Services

CMHS leads Federal efforts to treat mental illnesses by promoting mental health and by preventing the

development or worsening of mental illness when possible. Congress created CMHS to bring new hope to adults who have serious mental illnesses and to children with serious emotional disorders. CMHS was established under the 1992 ADAMHA Reorganization Act, Public Law 102-321, that mandates CMHS's leadership role in delivering mental health services, generating and applying new knowledge, and establishing national mental health policy (http://thomas.loc.gov/cgi-bin/query/z?c102:S.1306.ENR:). Specifically, the act calls for CMHS to carry out 14 specific responsibilities, including "develop and coordinate Federal prevention policies and programs and to assure increased focus on the prevention of mental illness and the promotion of mental health."

CMHS pursues its mission as follows:

- Helps States improve and increase the quality and range of their treatment, rehabilitation, and support services for people with mental illness, their families, and communities.
- Encourages a range of programs—such as systems of care—to respond to the increasing number of mental, emotional, and behavioral problems among America's children.
- Supports outreach and case management programs for the thousands of Americans with severe mental illness who are homeless and supports the development and adoption of "models" for improving services.
- Promotes consumer participation in the design, financing, and delivery of mental health and related support services.
- Collects new data, critically evaluates CMHS initiatives to determine what works, and disseminates the latest information to the field.
- Works with other Federal agencies and private-sector organizations whose programs and policies enhance mental health services delivery and advance policy development.

Office of Minority Health

The Office of Minority Health (OMH), while not a provider of mental health services and information, is providing important leadership and guidance for ensuring cultural competence in health care. (See *Focus* article: Culture Counts in Mental Health Services and Research.) OMH, which works within the Health Resources and Services Administration and across all HHS agencies, recently issued *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (http://www.omhrc.gov/CLAS/finalcultural1a.htm), which presents 14 standards for correcting inequities that currently exist in the provision of health services. The standards "are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services."

Linguistic appropriateness also is the subject of Executive Order 13166 (Improving Access to Services for Persons With Limited English Proficiency) issued in August 2000 (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2000_register&docid=fr16au00-137.pdf). The order applies to all federally conducted programs and activities and requires agencies to publish guidance documents. HHS has submitted its strategic plan (http://www.hhs.gov/gateway/language/languagememo.html) and provides policy guidance (http://www.hhs.gov/ocr/lep/) in English as well as Spanish and Chinese.

Children's Mental Health Is National Priority

In the public health model, data tell the story and drive the action. For children's mental health, the data support a blueprint for change, for reducing the burden of suffering by children with mental health needs and their families.

In releasing a National Action Agenda for Children's Mental Health, Surgeon General David Satcher recently said, "Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by the very institutions and systems that were created to take care of them" (http://www.surgeongeneral.gov/cmh/). He reported these facts:

- In the United States, 1 in 10 children and adolescents suffers from mental illness severe enough to cause some level of impairment.
- In any given year, fewer than 1 in 5 of these children receives needed treatment.
- The Nation lacks a unified infrastructure to help these children.
- Too often, children who are not identified as having mental health problems and who do not receive services end up in jail.

The agenda reflects the culmination in a series of activities, including the Surgeon General's Listening Session on Children's Mental Health in June 2000, the Surgeon General's Conference on Children's Mental Health in September 2000 (http://www.surgeongeneral.gov/cmh/default.htm), and *Mental Health: A Report of the Surgeon General*, released 2 years ago (http://www.surgeongeneral.gov/library/mentalhealth/home.html). Also originating from the Surgeon General's office are two more documents related to children's mental health: *Youth Violence: A Report of the Surgeon General* (http://www.surgeongeneral.gov/library/youthviolence/youvioreport.htm), issued in January 2001, and *National Strategy for Suicide Prevention: Goals and Objectives for Action* published in May 2001 (http://www.mentalhealth.org/suicideprevention/).

The emphasis on mental health is tied to the Surgeon General's mission to ensure that every child has an optimal chance for a healthy start in life. This premise prevails: "Mental health is a critical component of children's learning and general health." The national agenda is driven by these guiding principles:

- Promote the recognition of mental health as an essential part of child health.
- Integrate family, child, and youth-centered mental health services into all systems that serve children and youth.
- Engage families and incorporate the perspectives of children and youth in the development of all mental health care planning.
- Develop and enhance a public-private health infrastructure to support these efforts to the fullest extent possible.

Eight goals and multiple action steps are identified, including the wide adoption of science-based prevention and treatment services as well as continued research. The specific goals follow:

1. Promote public awareness of children's mental health issues and reduce stigma associated with mental illness.

2. Continue to develop, disseminate, and implement scientifically proven prevention and treatment services in the field of children's mental health.
3. Improve the assessment of and recognition of mental health needs in children.
4. Eliminate racial/ethnic and socioeconomic disparities in access to mental health care services.
5. Improve the infrastructure for children's mental health services, including support for scientifically proven interventions across professions.
6. Increase access to and coordination of quality mental health care services.
7. Train frontline providers to recognize and manage mental health issues and educate mental health care providers about scientifically proven prevention and treatment services.
8. Monitor the access to and coordination of quality mental health care services.

“It will take the efforts of all of us at the Federal, State, and local level to implement the action steps outlined in this agenda. I am confident that we will succeed,” said Dr. Satcher.

SPOTLIGHT

Mental Health Groups Take on Terrorism

Mental health organizations have made many resources available to support Americans following the September 11 attack on America. They are providing information and counseling services to survivors; fire, police, and other emergency workers; and to the many other millions of people directly and indirectly affected. Their Web sites abound with all kinds of help and support, from searchable databases for locating mental health professionals to tips for talking with children, to confidential screening tests for depression. And they continue to update the sites; mental health issues related to terrorism are expected to affect our Nation for a long time.

The National Mental Health Association (NMHA) (http://www.nmha.org) and its affiliates have been supporting and coordinating treatment and counseling activities in the New York City and Washington, DC, areas. For example, the NMHA affiliate in Nassau County, NY, trained more than 100 school psychologists and social workers in just a few days. The New York City affiliate has expanded the staff for the LifeNet telephone helpline.

“HHS Responds: Helping America Heal” (http://www.hhs.gov/hottopics/healing/gethelp.html) lists toll-free numbers and links for a wide range of resources, including help for children and families. The U.S. Department of Health and Human Services also presents up-to-the-minute information on emergency preparedness and response regarding anthrax and biological incidents (http://www.hhs.gov/hottopics/healing/biological.html).

The Knowledge Exchange Network Web site of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, (http://www.mentalhealth.org) has a special section called "Disaster

Mental Health" (http://www.mentalhealth.org/cmhs/EmergencyServices/), which is designed to meet the needs of survivors and responders.

The U.S. Department of Education (http://www.ed.gov/inits/september11/index.html) offers "Helping Children Understand the Terrorist Attacks," which is available in Spanish and has information, resources, and links. The National Association of School Psychologists http://www.nasponline.org/NEAT/crisis_0911.html) provides two new publications, *The Model of Hope: A Practical Guide for Coping With Tragedy* (http://www.nasponline.org/NEAT/modelhope.html) and *Crisis Response: Caring for the Caregivers* (http://www.nasponline.org/NEAT/caregivers.html). Of special interest are the translations available online for *A National Tragedy – Promoting Tolerance and Peace in Children: Tips for Parents and Schools*. This document is available in Arabic, Chinese, Farsi, Spanish, Urdu, and Vietnamese at http://www.nasponline.org/NEAT/crisis_0911.html#resources.

The American Psychiatric Association (http://www.psych.org/) has resources, tools, and other links under "Coping With Terrorism." Among the offerings are 20 tips for parents to use in talking with their children about war and terrorism.

A search for "help with trauma" brought up information from the American Psychological Association (http://www.apa.org/) on how to find a psychologist, online brochures, and a help center. "Response to the Terrorist Attack" sponsored by the National Association of Social Workers (http://www.naswdc.org/) has numerous resource links, tips for families, and suggestions for how social workers can get involved.

RESOURCES

Mental Health Information Is a Click Away

Known as KEN, the Knowledge Exchange Network Web site of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, (http://www.mentalhealth.org) attracts more than two million visitors every month. The site serves health professionals and consumers. Special sections include pages for kids and parents and a locator map for community mental health services.

The National Institute of Mental Health, National Institutes of Health, (http://www.nimh.nih.gov) seeks to eliminate the burden of mental disease through research. The site has information for researchers, practitioners, and the public, including clinical trials, funding opportunities, and research findings.

The National Mental Health Association (NMHA) (http://www.nmha.org) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans, especially the 54 million individuals with mental disorders, through advocacy, education, research, and service. Its Mental Health Information Center number is 1-800-969-NMHA [6642].

The National Alliance for the Mentally Ill (http://www.nami.org/) is a nonprofit, grassroots, self-help, support, and advocacy organization of consumers, families, and friends of people with severe mental illnesses such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders. The organization has some 1,200 State and local affiliates and a HelpLine available 24 hours a day, 7 days a week (1-800-950-NAMI [6264]).

The American Psychiatric Association (http://www.psych.org/) serves members and the public with legislative news, publications, a job bank, online continuing medical education, library and archives, and clinical resources.

The American Psychological Association (http://www.apa.org/) has news, full-text articles, job postings, conference listings, and substantial online information on mental health topics.

The National Association of Social Workers (http://www.naswdc.org/) provides an online directory of clinical social workers (searchable by specialty, city, State, ZIP Code, or name), a press room, practice updates, and such special sections as "Diversity and Equity Issues."

healthfinder® (http://www.healthfinder.gov) has many dozens of mental health-related listings, including organizations like the National Association of Rural Mental Health (http://www.narmh.org/) and the American Academy of Child and Adolescent Psychiatry (http://www.aacap.org/).

Healthy People 2010: Mental Health and Mental Disorders

Healthy People 2010 has 14 objectives in Focus Area 18: Mental Health and Mental Disorders (http://www.health.gov/healthypeople/Document/HTML/Volume2/18Mental.htm):

18-1	Reduce the suicide rate.
18-2	Reduce the rate of suicide attempts by adolescents.
18-3	Reduce the proportion of homeless adults who have serious mental illness.
18-4	Increase the proportion of persons with serious mental illness who are employed.
18-5	(Developmental) Reduce the relapse rates for persons with eating disorders including anorexia nervosa and bulimia nervosa.
18-6	(Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment.
18-7	(Developmental) Increase the proportion of children with mental health problems who receive treatment.
18-8	(Developmental) Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems.
18-9	Increase the proportion of adults with mental disorders who receive treatment.
18-10	(Developmental) Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.
18-11	(Developmental) Increase the proportion of local governments with community-based jail

	diversion programs for adults with serious mental illness.
18-12	Increase the number of States and the District of Columbia that track consumers' satisfaction with the mental health services they receive.
18-13	(Developmental) Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses cultural competence.
18-14	Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons.

ACTIVITIES

Online

Injury and Violence Prevention

The Centers for Disease Control and Prevention (CDC) published ***School Health Guidelines To Prevent Unintentional Injuries and Violence*** in a recent *Morbidity and Mortality Weekly Report*, Recommendations and Reports series. The report identifies school policies and practices that are most likely to be effective in preventing unintentional injury (such as playground and sports injuries), violence, and suicide among young people. The *Guidelines* are available online at www.cdc.gov/mmwr/indrr_2001.html.

Health Communication

The Administration for Children and Families recently made available the publication, ***Coping With Disaster: Suggestions for Helping Children With Cognitive Disabilities***. The publication presents information about what to expect and some strategies for use with children with mental retardation, autism, or other disabilities affecting learning, communication, and understanding. This guide provides information on specific strategies for children with unique needs and resources for coping with disaster. It is available online in English, Spanish, Chinese, and Vietnamese at www.acf.dhhs.gov/sept11/public.htm.

A new Web site funded by the Agency for Healthcare Research and Quality (AHRQ) **teaches hospital-based physicians and nurses how to diagnose and treat rare infections and exposures to bioterrorist agents such as anthrax and smallpox**. The site currently offers five online courses through the University of Alabama Birmingham Office of Continuing Medical Education for emergency department clinicians, including physicians, nurses, radiologists, pathologists and infection control practitioners. The Web address is www.bioterrorism.uab.edu.

In the ongoing war against Internet health fraud, Federal and State government organizations have united, in an effort dubbed **Operation Cure.All**, to crack down on unscrupulous marketers who use the Internet to prey on the

sickest and most vulnerable consumers. Operation Cure.All, a partnership of the Federal Trade Commission, the Food and Drug Administration, Health Canada (the Canadian Federal health department), and various State attorneys general and State health departments, combines a law enforcement effort with a consumer education campaign. The FDA's efforts to curtail online marketing of unapproved drugs have resulted in at least 12 product seizures, 11 product recalls, 43 arrests, and 22 convictions. The FDA continues to investigate more than 80 incidences of Internet health fraud and unapproved drug products. Consumers who find a Web site they think is illegally selling human drugs, animal drugs, medical devices, biological products, foods, dietary supplements, or cosmetics over the Internet, they can report the site using the form at www.fda.gov/oc/buyonline/buyonlineform.htm. For information about buying drugs online, visit www.fda.gov/oc/buyonline/default.htm.

Mental Health and Mental Disorders

The Administration on Aging offers a Web page of links for information related to suicide and the elderly at www.aoa.gov/NAIC/Notes/suicide.html, including **Aging Internet Information Notes: Suicide and the Elderly**, a link to *The Surgeon General's Call To Action To Prevent Suicide* (www.surgeongeneral.gov/library/calltoaction/default.htm), and links to data sources for prevention facts and prevalence statistics.

Crosscutting

Health Communication

AHRQ recently released ***A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach***. This publication, available online at www.ahrq.gov/ppip/manual/manual.htm, is from AHRQ's Put Prevention Into Practice Program. The *Guide* provides help in the development of a system for delivering clinical preventive services in the primary care setting. The *Guide* is also available from the AHRQ Publications Clearinghouse by calling (800) 358-9295.

In response to the recent outbreaks of anthrax, CDC has developed an educational video, **Protecting Your Health**, for people who process, sort, or deliver mail. This 15-minute video was developed for people who work in a variety of settings, from small mail rooms to large processing and distribution centers. The video includes basic information about anthrax, strategies for protecting workers from anthrax exposures, and methods for detecting and responding to a suspicious letter or package. Copies of the video can be obtained from the Public Health Foundation (PHF) by calling 1 (877) 252-1200 or visiting the PHF Web site at http://bookstore.phf.org.

Tobacco Use

CDC recently released ***The Tobacco-Free Sports Playbook***, designed to help coaches, school administrators, and State and local health departments reach out to young people with messages about the importance of choosing a healthy, active, and tobacco-free lifestyle. *The Playbook* describes a step-by-step game plan for incorporating sports into tobacco-free activities. *The Playbook* is available online at www.cdc.gov/tobacco/news.htm#Playbook or by calling (770) 488-5747.

MEETINGS

National Association of School Pyschologists 34th Annual Convention: Overcoming Barriers, Increasing Access, Serving All Children. Chicago, IL. (301)657-0270 or visit www.nasponline.org/conventions/prel_prog02.html. **February 26–March 2, 2002**.

16th National Conference on Chronic Disease Prevention and Control—Cultivating Healthier Communities Through Research, Policy, and Practice. Atlanta, GA. (703)538-1798 or visit www.cdc.gov/nccdphp/conference/index.htm. **February 27–March 1, 2002**.

Prevent Child Abuse America's 2002 National Conference. Dallas, TX. (312)663-3520, Ext. 221, or visit www.preventchildabuse.org/events/conference.htm. **March 2–5, 2002**.

13th International Conference on the Reduction of Drug Related Harm and the 2nd International Harm Reduction Congress on Women and Drugs. Ljubljana, Slovenia. Visit www.ihrc2002.net/1.html. **March 3–7, 2002**.

International Conference on Emerging Infectious Diseases. Atlanta, GA. (202)942-9248 or visit www.cdc.gov/iceid/. **March 24–27, 2002**.

35th Annual Conference on Suicide Prevention: Opportunities and Challenges Along the Continuum of Health and Illness. Bethesda, MD. (202)237-2280 or visit www.suicidology.org. **April 10–13, 2002**.

3rd National Congress On Childhood Emergencies. Dallas, TX. (202)884-6859 or visit www.ems-c.org/2002Congress/. **April 15–17, 2002**.

6th Annual International Child Passenger Safety Technical Conference. Sacramento, CA. (708)386-7179 or visit www.cipsafe.org/icpstc/2002/. **April 20–24, 2002**.

Prevention VII Conference: Obesity. Honolulu, HI. Visit www.americanheart.org/presenter.jhtml?identifier=1200035. **April 27–28, 2002**.

Center for Substance Abuse Prevention First State Prevention Summit. Phoenix, AZ. (301)443-6085 **April 29–May 1, 2002.**

11th International Conference on Safe Communities. Ontario, Quebec, Canada. 416.964.8296 or visit www.who2002.com/scf.html. **May 7–9, 2002**.

6th World Conference on Injury Prevention and Control. Montreal, Quebec, Canada. (514)848-1133 or visit www.trauma2002.com. **May 12–15, 2002**.

8th National Clean Cities Conference. Oklahoma City, OK. (303)275 4326 or visit www.ccities.doe.gov/okconference.shtml. **May 12–15, 2002**.

Mental Health Issues in Juvenile Justice. Tucson, AZ. (775)784-6225 or visit http://training.ncjfcj.unr.edu/Conferences.htm. **May 19–22, 2002**.

National Peer Helpers Association 16th Annual Conference. Baltimore, MD. (877)314-7337 or visit www.peerhelping.org. **June 23–25, 2002**.

National Environmental Health Association's 2002 Chemical and Bioterrorism Preparedness Conference. Minneapolis, MN. (303)756-9090, Ext. 0, or visit www.neha.org/tracks.html. **June 30–July3, 2002**.

3rd MIM Pan-African Conference on Malaria. Arusha, Tanzania. http://mim.nih.gov/english/events/3rd_mim_conf/. **November 2002**.

IN THE LITERATURE

Mental Health and Mental Disorders

Assessment Strategies for School-Based Mental Health Counseling. Grier, R., et al. *Journal of School Health* 71(2001): 467-9.

This article describes best practices for assessing the mental health needs of students in the school setting. Assessments can include a description not only of the student but also of the student's school and home environments. Assessments of mental health needs also must be sensitive to cultural differences and unique needs.

Self-assessments often offer the best measure of a student's mental health needs. It is often very effective to include an assessment of the student's strengths and interests as well as his or her problems and needs. This kind of self-assessment can be done informally through such techniques as asking the student what others would identify as his or her strengths or asking what the student could help someone with or teach to someone else.

Assessing the mental health needs of children who are recent immigrants to the United States can prove especially challenging. Techniques that help overcome cultural bias include translating interview and assessment tools into the student's language, incorporating into the interview or assessment tools questions about religion or beliefs, asking open-ended questions, and asking the student to explain or define meanings (e.g., "What does this mean in your culture?").

Although sharing information with other health professionals can be valuable, it is imperative that staff obtain a release from the individual in order to protect confidentiality. Often mental health professionals are most effective when they are working together with professionals and staff who are serving the child within other health areas.

Ethnic Disparities in Unmet Need for Alcoholism, Drug Abuse, and Mental Health Care. Wells, K., et al. *American Journal of Psychiatry* 158(December 2001): 2027-32.

Approximately 23 percent of the U.S. population suffers from mental illness during any 12-month period. Binge drinking among adults is reported at 17 percent. Ensuring that ethnic minorities receive access to quality care for mental illness, alcoholism, and drug abuse is important, especially for new immigrants to this country. This study compared access and quality of care among non-Hispanic whites, African Americans, and Hispanics.

Researchers looked at these issues from both a clinical perspective and the consumer point of view. From more than 9,000 responses to the Healthcare for Communities survey, researchers categorized respondents as African American, Hispanic, or non-Hispanic white. Clinical need was assessed using such tools as the Composite International Diagnostic Interview and the Alcohol Use Disorders Identification Test. Respondents were asked if they "needed help for emotional or mental health problems" or "needed help for alcohol or other drug problems." Access to care was measured by any use of alcoholism, drug abuse, or mental health care treatment.

The study found that African Americans and Hispanics consistently had less access to care, poorer quality of care, and greater unmet need for alcoholism, drug abuse, and mental health treatment than whites. The percentage of African Americans with unmet need in these three areas, for example, was twice as high as that for whites.

Policies that would help address these unmet needs include programs that extend insurance coverage to the near-poor and programs that seek to improve access to and quality of care for ethnic minorities.

Impact of Generalized Social Anxiety Disorder in Managed Care. Katzelnick, D.J., et al. *American Journal of Psychiatry* 158(December 2001): 1999-2007.

Generalized anxiety disorder affects approximately 8 percent of the U.S. population. It is associated with lower wages, lower educational levels, and fewer managerial, technical, and professional occupations. This study examined the effects of generalized anxiety disorder on members of a Midwest health maintenance organization (HMO), compared to HMO members with depression or other mental illness and members without any mental illness.

The study was a three-phase mail and telephone survey conducted in 1998 among members of Dean Health Plan. Researchers used a brief mental health screener to determine if respondents were suffering from generalized anxiety disorder only, from depression only, or from generalized anxiety disorder in combination with some other mental illness.

With anxiety disorder alone, respondents averaged almost nine outpatient visits annually. Those with pure major depression averaged close to 10 outpatient visits annually, and those with anxiety disorder along with another psychopathology, almost 11. In terms of annual dollars, the first group utilized an average of about $2500 per member, the second group almost $2800, and the third group more than $3,000.

Regarding quality-of-life measures, respondents with pure anxiety disorder reported significantly lower scores in most quality-of-life categories than those with no diagnosis of mental illness; respondents with anxiety disorder in conjunction with another psychopathology also reported lower scores. Respondents with major depression alone reported the lowest quality-of-life scores on almost all categories.

Researchers recommended expanding treatments to the primary care setting that have been found effective in research settings for generalized social anxiety disorder.

The Consequences of Stigma for the Self-Esteem of People With Mental Illness. Link, B.G., et al. *Psychiatric Service* 52(December 2001): 1621-6.

People form opinions about mental illness based on family beliefs, personal experience, media messages, and other factors. Some people come to associate mental illness with a stigma of failure, social rejection, low intelligence, and low competency. This study examined the effect that such a stigma has on persons with mental illness.

Between 1995 and 1997, researchers interviewed 70 volunteer members of a "clubhouse" program for people with mental illness. The interviews were conducted over 6 months and 24 months after interviewees had participated in a program on coping with stigma. According to the study findings, the coping program made no significant difference in respondents' perceptions of stigma, symptoms of depression, or self-esteem.

A significant percentage of respondents indicated that they felt like a failure or that they felt useless at times. There was a significant and strong association between these feelings of low self-esteem and feelings of stigma regarding mental illness. Many respondents also said they used social withdrawal as a means of dealing with social stigma.

Contrary to much popular opinion, feelings of stigma did affect the self-esteem of persons with mental illness, further hindering their recovery process.

Health Communication

Staying Healthy: The Salience and Meaning of Health Maintenance Behaviors Among Rural Older Adults in North Carolina. Arcury, T.A., et al. *Social Science & Medicine* 53(2001): 1541-56.

Health promotion and disease prevention practices and behaviors can increase functioning and enhance and extend life, especially for older people. This study examined the beliefs of elderly residents of two rural counties in North Carolina. Study participants were asked what a woman or man their age should do to stay healthy; they were then asked to define each of the elements they had named in response to the question.

Participants comprised 145 adults aged 70 or older recruited from one of 45 diverse sites such as home health care agencies, senior centers, and churches. One-third of the participants were African American, one-third were European American, and one-third were Native American. Data were collected quarterly over 1 year using personal interviews and fixed-response instruments such as food frequency questionnaires. Participants represented a variety of functional abilities, educational backgrounds, and past professions.

Seven health maintenance areas emerged as very important to these rural residents: eating right, drinking water, "taking" exercise, staying busy, being with people, trusting in God and participating in church (one area), and taking care of yourself. Researchers were especially interested in participants' definitions of each area, which also varied. For example, "taking exercise" to some meant formal exercise such as walking on a treadmill; to others it meant moving around the house or yard and staying out of the rocking chair.

Analyzing participants' definitions of these seven areas highlighted four underlying themes: "balance and moderation" (a balanced diet, not exerting yourself too much in exercise, etc.), "the holistic view of health" (e.g., daily religious devotions along with eating a good diet), "social integration" (keeping busy by socializing, staying active in church service, etc.), and "personal responsibility" for choosing the right foods, getting oneself out to exercise, and choosing other health-promoting behaviors.

Educational and School-Based Programs

Reconciling Concept and Context: The Dilemma of Implementation in School-Based Health Promotion. MacDonald, M.A., and Green, L.W. *Health Education & Behavior* 28(December 2001): 749-68.

In order to combat substance abuse among youth in British Columbia, the Alcohol and Drug Program of British Columbia initiated a pilot School-Based Prevention Project in 1992. Under this program, a prevention worker was hired to implement a substance abuse prevention model in each secondary school.

The prevention workers were trained in the prevention model, which was a general process rather than a specific program. The prevention model consisted of six steps: go into the school, set up a prevention steering committee, identify the problem, determine the causes, develop prevention activities, and review their progress.

Results showed that, in fact, prevention workers spent much more of their time providing intervention services for existing problems or crises than they did initiating prevention activities. In many cases, school personnel assumed this service model and resisted attempts to initiate a prevention plan. Those who were most successful in adhering to the prevention goals of the program were workers who did not come from a treatment background or who had experience working in community settings with all kinds of youth.

Gaining entry into the school setting (i.e., establishing credibility) was very challenging for many workers. Many workers spent a great deal of time and energy establishing legitimacy, and many fell into the service role in an attempt to gain entry.

In many cases the prevention workers themselves had not thoroughly learned and understood the model so they did not believe in or "sell" the model to the school they were serving. Most workers decided that the model did not fit the school setting very well. Few workers implemented the prevention model as it was presented to them. Some approximated the model and others reinvented it to fit their individual circumstances. So, although the prevention model looked good on paper, it was difficult to implement.

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Access to Health Care

The U.S. Department of Health and Human Services and ABC Radio Networks are working together to sponsor **Closing the Health Gap** (www.healthgap.omhrc.gov/#), a national campaign to bring the best health information to African American communities and help African American consumers take charge of their health. The site offers health tips and resources for further information to help people get started or continue on the road to a healthier life.

Diabetes

The Agency for Healthcare Research and Quality has made available online a fact sheet, **Diabetes Disparities Among Racial and Ethnic Minorities**, at www.ahrq.gov/research/diabdisp.htm. This fact sheet describes the

disparities in the prevalence of diabetes and related illnesses and offers suggestions for reducing these disparities.

Immunization and Infectious Diseases

Disease-causing microbes that have become resistant to drug therapy are an increasing public health problem, according to the Food and Drug Administration (www.fda.gov/oc/opacom/hottopics/anti_resist.html). Tuberculosis, gonorrhea, malaria, and childhood ear infections are just a few of the diseases that have become hard to treat with antibiotic drugs. Part of the problem is that bacteria and other microorganisms that cause infections are remarkably resilient and can develop ways to survive drugs meant to kill or weaken them. This **antibiotic resistance**, also known as antimicrobial resistance or drug resistance, is due largely to the increasing use of antibiotics.

Substance Abuse

In December 2001, the **U.S. Drug Enforcement Agency** hosted a ground-breaking symposium on narco-terrorism, calling attention to the link between drug trafficking and terrorism. The gathering of enforcement and community leaders was moderated by Robert Novak, the long-time syndicated columnist and TV political commentator. Information on this symposium is online at www.usdoj.gov/dea/pubs/newsletters/121101internet.html.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

The mission of the Office of Disease Prevention and Health Promotion (ODPHP) is to provide leadership for disease prevention and health promotion among Americans by stimulating and coordinating prevention activities. *Prevention Report* is a service of ODPHP.