



Depression and Bipolar
Support Alliance

Inclusiveness in DBSA Chapters

The Spirit of Inclusiveness

The Depression and Bipolar Support Alliance's mission is *to improve the lives of people living with mood disorders.*

This includes all people living with mood disorders. Inherent in that mission is the spirit of inclusiveness.

in·clu·sive (ĭn-klŭ'sĭv) *adj.*-- Recognizing the positive effects of a fair community and demonstrating an understanding of diversity and fairness through compassionate participation in a diverse society. Further, inclusiveness exists in various forms, including but not limited to race, ethnicity, culture, talent, ability and disability, sex/gender, sexual orientation, age, religion, language, socio-economic status, and learning styles.

An inclusive spirit means more than just *saying* that DBSA's services are open to anyone. As an organization DBSA must actively work to not just open the doors to those that may happen to enter, but also put out the welcome mat of outreach to bring in people that wouldn't otherwise feel as though they belonged.

DBSA Values

DBSA's national office and local DBSA chapters state clearly the principles and guidelines by which the organization is guided. These principles and guidelines can be found on the document distributed by DBSA entitled "DBSA Chapter Fundamentals."

Within these principles and guidelines are five statements that speak directly to the topic of inclusiveness. These statements instruct DBSA leadership on the national and local levels on the importance of creating an inclusive atmosphere for chapter activities.

Here are just some of the DBSA statements that apply directly to the topic of inclusiveness:

DBSA Chapter Principles

- **Safety and Acceptance**
Chapter activities and support groups are welcoming to all, and foster a nurturing atmosphere.
- **Accessibility**
Support groups are free of charge, and all activities are accessible to anyone who can benefit from them.

DBSA Support Group Guidelines

- **We are all equal**
Accept cultural, linguistic, social and racial differences and promote their acceptance.
- **Differences of opinion are o.k.**
We are ALL entitled to our own point of view.
- **It's everyone's responsibility to make the discussion groups a safe place to share.**
We respect confidentiality, treat each other with respect and kindness, and show compassion.

Why Inclusiveness in DBSA Chapters?

DBSA chapters depend upon the spirit of inclusiveness to operate effectively. Each chapter is open to anyone in the community that is affected by a mood disorder. In order for this to work effectively, DBSA chapters must seem inviting in their location, atmosphere, culture and presentation.

A key function of DBSA chapters is providing *support* to people affected by mood disorders. Before support can be administered from person to person, each person involved must feel welcome, comfortable and accepted by the other(s). The spirit of inclusiveness is vital to the health and operation of a DBSA chapter.

Culture and Mental Health Facts

To demonstrate the impact of mental illness on different, non-majority, cultures, and the significant need for cultural inclusion efforts by DBSA, following are facts about several major cultures and their mental health experiences in the United States. These facts were compiled by, and included with permission from, the Multicultural Action Center of the National Alliance for the Mentally Ill (retrieved from www.nami.org on October 1, 2004).

Did you know...

African American Community Mental Health Facts Rates of Mental Illness

- The rates of mental illness in this community are similar to non-Hispanic whites. African Americans are less likely to suffer from major depression and more likely to suffer from phobias than non-Hispanic whites.¹
- Somatization is more common among African Americans (15%) than among whites (9%).²
- Studies revealed gender differences in rates of mental illnesses. Prevalence rates of depression, anxiety disorder, and phobias are higher among African American women than men.³
- The Commonwealth Fund Survey of the Health of Adolescent Girls, reported that African American girls have lower rates of depressive symptoms of all racial/ethnic gender groups.⁴
- Official statistics indicate that African Americans are less likely to commit suicide.⁵ The suicide rate among African Americans ages 10 -14 increased 233%, compared to 120% of comparable non-Hispanics.⁶
- African Americans are likely to be exposed to violence-related trauma, as were the large number of African American soldiers assigned to war zones in Vietnam (21%). Exposure to trauma leads to increased vulnerability to mental disorders.^{7 2}

Barriers to Treatment

- African Americans make up a large part of the homeless population. (40%)⁸
- Nearly half of all prisoners in State and Federal jurisdictions are African American, as are nearly 40% of juveniles in legal custody.⁹
- African Americans are more likely to use emergency services, but less likely to seek treatment from a primary care provider than from a mental health specialist.¹⁰
- Among clinically trained mental health professionals, only 2% of psychiatrists, 2% psychologists, and 4% of social workers are African American.¹¹
- Nearly one-fourth of African Americans are uninsured, a percentage 1.5 times greater than the white rate.¹²
- The mental health problems among African Americans are especially likely to occur jointly with substance abuse problems, as well as with HIV infection or AIDs.¹³
- African American patients released from inpatient mental health care only received follow-up care 33% of the time, compared with 54% for whites.¹⁴

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Did you know...

American Indian and Alaska Native Communities Mental Health Facts

- No large-scale epidemiological studies of American Indian and Alaska Natives have yet been published. One small study with a 20-year follow up found the lifetime prevalence of mental disorders to be 70%.¹
- Native Americans have very high prevalence of substance use, alcohol dependence, and need for illicit drug abuse treatment.²
- The Great Smoky Mountain Study found that Native American children had similar rates of disorders (17%) compared to white children (19%).³
- The suicide rate for Native Americans is 1.5 times the national rate. Native American males ages 15 to 24 account for two-thirds of all Native American suicides.⁴
- Over one quarter of Native Americans live in poverty, compared to 8% of whites.⁵
- Native Americans made up less than 1% of the U.S. population in 1999, yet they accounted for 2.4% of all admissions to publicly funded substance abuse treatment facilities.⁶
- Just under half of Native Americans have job-based health coverage compared to 72% of whites.⁷
- Native Americans use of mental health services are limited by lack of research.
- Traditional healing is used by a majority of Native Americans.⁸
- Native Americans rate their healer's advice 61.4% higher than their physician's advice.
- Only 14.8% of the patients seeing healers tell their physician about their use.⁹
- There are over 550 tribal groups in the U.S. and over 1000 languages for 2.2 million people.¹⁰

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Did you know...

Asian American and Pacific Islander Communities (AA/PIs) Mental Health Facts

- There is very little research about mental health issues in these populations. Overall prevalence rates of diagnosable mental illnesses among AA/PIs are similar to those of the Caucasian population.
- Asian Americans and Pacific Islanders have the lowest rates of utilization of mental health services among ethnic populations.ⁱ
- AA/PIs show higher levels of depressive symptoms than whites. South Asian refugees reported the highest rates among Asian groups.ⁱⁱ
- The Chinese American Psychiatric Epidemiologic Study (CAPES study) found a lifetime prevalence rate of about 7% (lifetime) and a 3% rate over one year. The National Comorbidity Study (NCS) reported even higher rates of major depression among Chinese Americans (17% for lifetime and 10% current).ⁱⁱⁱ
- The word depression does not exist in certain Asian languages (E.g. Chinese).
- The suicide rates for Filipino (3.5%), Chinese (8.3%), and Japanese (9.1%) Americans are substantially lower than the suicide rate of white Americans (12.8%).^{iv}
- Among elderly women of all ethnic or racial groups, Asians have the highest suicide rate.^v
- According to mental health care providers: Asian American women ages 15-24 have a higher rate of suicide than Whites, Blacks, and Hispanics in that age group.^{vi}
- The Commonwealth Fund Survey of the Health of Adolescent Girls, reported that Asian American adolescent girls had the highest rates of depressive symptoms of all 2 racial/ethnic and gender groups.^{vii}
- Southeast Asians suffer from particularly high rates of depression and post-traumatic stress disorder and exhibit more than twice the need for outpatient mental health services than the general Asian population.^{viii}
- Suicide rates are higher than the national average for some groups of Asian Americans.
- The suicide rate among Asian Americans and Pacific Islanders in California is similar to that of the total population.^{ix}
- Many Southeast Asian refugees are at risk for post-traumatic stress disorder (PTSD) associated with trauma experienced before and after immigration to the U.S. One study found that 70% of Southeast Asian refugees receiving mental health care met diagnostic criteria for PTSD.
- In a study of Cambodian adolescents who survived Pol Pot's concentration camps, nearly half experienced PTSD and 41% suffered from depression 10 years after leaving Cambodia.^x
- Approximately 70 AAPI providers are available for every 100,000 AA/PIs in the U.S., compared to 173 per 100,000 whites.^{xi}

- AA/PIs appear to have the extremely low utilization of mental health services relative to other U.S. populations. In the CAPES study, only 17% of those experiencing problems sought care.^{xii}
- A national study concluded that Asian Americans were one quarter as likely as whites to seek mental health services and half as likely as Latinos and African Americans.^{xiii 2 3}

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Did you know...

Latino Community Mental Health Facts Rates of Mental Illness

- The rates of mental illnesses in the Latino community are fairly similar to whites.
- Latinos are identified as a high-risk group for depression, anxiety, and substance abuse.¹
- Deborah Duran established correlation between acculturation and depression (Duran,1995)².
- Women and Latinos are more likely to experience a major depressive episode.³
- Prevalence of depression is higher in Latino women (46%) than Latino men (19.6%).⁴
- The Common Wealth Fund Survey revealed that surveyed Latino and Asian American girls exhibited more depressive symptoms than the African American or white girls.⁵
- Among female high-school students in 1997, the rate of attempted suicide among Latino girls (14.9%) was one-and-a-half times that of African American (9.0%) and non-Hispanic white (10.3%) girls.⁶
- Close to one out of every three Latino female (30.3%) high-school students in 1997 had seriously considered committing suicide.⁷
- There are higher rates of mental illness among U.S. born and long-term residents than among recent Latino immigrants. Place of birth has a significant correlation with the subsequent risk for most psychiatric disorders.⁸
- A study found conclusively that long-term residence in the United States significantly increased rates in mental disorders, with particularly dramatic increases in the rates of substance abuse.^{9,2}
- A research on suicidal ideation found that foreign-born Mexican Americans are at significantly lower risk of suicide and depression than those born in the United States.¹⁰

Barriers to Treatment

- Latinos are twice as likely to seek treatment for mental disorders in other settings, such as general health care or the clergy, than in mental health specialty settings.
- Among Latinos with mental disorders, fewer than 1 in 11 contact mental health care specialists, while fewer than 1 in 5 contact general health care providers.¹¹
- The statistics become more alarming among Latino immigrants with mental disorders. Fewer than 1 in 20 Latino immigrants use services from mental health specialists, while less than 1 in 10-use services from general health care providers.¹²
- The existing studies about language skills of mental health professionals reveal that there are few Spanish-speaking and Latino providers.

- A national survey revealed that out of 596 licensed psychologists with active clinical practices who are members of the American Psychological Association, only 1 percent of the randomly selected sample identified themselves as Latino.¹³
- In 1999 CMHS reported the existence of 29 Latino mental health professionals for every 100,000 Latinos in the United States.
- The US Bureau of Census in 1993 reports that more than 1 in 4 Hispanics lives in a “linguistically isolated household” in the US. This reality plus the lack of bilingual mental health providers makes access to care harder for Latinos.
- Lack of culturally competent providers. A 2001 study by Kaiser Family Foundation and Harvard University found that whites believe that Latinos have access to the same or better opportunities for employment and the same access to health care despite obvious evidence to the contrary (Morin 2001).
- Cho and Solis, 2001, report that 51% of white health care providers believe that their patients do not adhere to medical treatments as a result of cultural or linguistic barriers.
- Of this same group – 56% report having no form of cultural competency training.^{2 3}
- Mental illness research does not adequately include Latinos. A 1998 study of the Office of Minority Health reported that states do not have appropriate health data for minority populations. The states that actually collect minority health data routinely break out black and white data only.
- Living in poverty has the most measurable effect on the rates of mental illness. People in the lowest socioeconomic status are about two to three times more likely than those in the highest strata to have a mental disorder.¹⁴
- The lack of services for Latinos worsens when dealing with Latino children and youth. Dr. Margarita Alegría reported during the Surgeon General’s conference on mental health and children that, “Latino youths have the highest rate of suicide, yet they are less likely to be identified by their caregivers as having problems (2000).”
- The Centers for Disease Control and Prevention (CDC) Youth Risk Survey found a 10.7 percent attempted suicide rate among Latino youth, compared with a 7.3 percent rate among African American youth and a 6.3 percent rate for White, non-Latino youth.
- Tragically, due to lack of cultural knowledge, Latino youth with mental illness are generally misdiagnosed as having anger problems or just conduct disorders.
- Latinos are over-represented in the criminal and juvenile justice system. Many of these Latinos have a misdiagnosed or not diagnosed mental illness. The Building Blocks for Youth report *Dónde Está La Justicia? A call for Action on Behalf of Latino and Latina Youth in the U.S. Justice System* (2002) recently highlighted the alarmingly disproportionate rates of Latino youth in the juvenile justice system. The report found that in almost

- every state, Latinos and African Americans are over-represented in the justice system and receive harsher treatment than
- Caucasian youth charged for the same types of offenses. E.G. In Los Angeles Co. in 1998, Latino youth were 2.0 times as likely as Caucasian youth to be arrested for drug offenses and in these cases, the admission rate for Latinos charged with drug offenses was 13 times the rate for Caucasian youth.
 - Many of these youth have emotional disorders and mental health problems. Different studies estimate that 50% to 70% of all youth in the juvenile justice system have mental health problems that usually go untreated or badly treated. ^{3 4}

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If Not You, Then Who?

It can be very easy for a DBSA chapter leader to determine that they are not the right person for the job of being inclusive. Chapter leaders are so busy with other tasks and responsibilities that to actively work toward inclusiveness can seem a daunting task.

Chapter leaders must, however, lead by example and set the tone for the group. All of the great advancements in making the world more inclusive have come from the small acts of one person. The chapter leader can be that one person in their chapter and community that makes the effort to support ALL persons affected by mood disorders.

If you fail to make the effort toward an inclusive organization, then who will be the one to do it? If not you, then who?

Many Differences...

Words like inclusiveness, diversity and multiculturalism often spark thoughts of the relationship between Americans of western European heritage, and people from African-American backgrounds. This is easily understandable as this relationship has been riddled with strife and strain for many years in the United States and similarly in other countries. However, there is more to consider than just this single racial struggle.

Some of the major considerations when working toward an inclusive organization include:

- * Ethnicity
- * Race
- * Gender
- * Age
- * Disability
 - Physical
 - Mental
 - Visual
 - Hearing
 - Speech
- * Sexual / Affectual Orientation
- * Religions / Spirituality
- * Education Level
- * Experience Level
- * Communication Styles
- * Learning Styles
- * Socioeconomic Situation
- * Cultural Experience
- * Etc... (any "differences" from YOU!)

Keeping all of these aspects of diversity in mind, and most importantly, keeping the *spirit* of inclusiveness in mind through your interactions, conversations, planning and group dynamics will help everyone feel more comfortable and supported.

Inclusive Language

Using appropriate terminology, and always using “people first” language is a great way to start ensuring an inclusive chapter atmosphere. Cultural labels are a challenging topic no matter how they are approached. Each individual has their own preference of how others refer to them. For instance a gentleman of German heritage, living in New York City may prefer to be called:

- German-American
- Caucasian
- White
- New Yorker
- Northeasterner
- Man
- Person
- Jim

The best, and most inclusive label for this person is “Jim.” As we all have slight differences in skin color, ancestry, geographic origin, gender, etc. we are all also individual human beings.

There are countless opinions on the “correct” terminology to use when referring to a person or a group of people. While it is primarily important to remember that each of those people are simply individuals like “Jim,” it can sometimes be helpful to have a method of referring to groups of individuals.

Sensitive Language Guide

The Sensitive Language Guide helps users meet the challenge of using sensitive or inclusive language by recognizing that the cultural and societal norms are different from geographic area to area, and are constantly evolving. Use this guide as a starting point to building a more sensitive lexicon for you and your chapter participants.

The guide created by Random House, Inc. in 2003 and can be found at <http://www.randomhouse.com/words/language/>. The site makes continual updates.

This user friendly site includes assistance when challenged by:

- Sexism
- Using gender-neutral terms for occupations, positions, roles, etc.
- Replacing the generic use of the pronoun *he*
- Referring to members of both sexes with parallel names, titles, or descriptions
- Race, Ethnicity, and National Origin
- Age
- Sexual Orientation

- Avoiding Depersonalization of Persons with Disabilities or Illnesses
- Avoiding Patronizing or Demeaning Expressions
- Avoiding Language That Excludes or Unnecessarily Emphasizes Differences

Overcoming Bias

Overcoming bias is at the root of becoming an inclusive leader and having an inclusive DBSA chapter. Defined by the experts, “bias” is:

According to Sondra Thiederman, Ph.D., author of Making Diversity Work (2003), *“Bias” is an inflexible belief about a particular kinship group.*

According to Webster’s Revised Unabridged Dictionary (2003), *“Bias” is a leaning of the mind; propensity or prepossession toward an object or view, not leaving the mind indifferent.*

Essentially, bias is a pre-held, influential belief about something, and in the context of this guide for inclusiveness, bias is the barrier to success. Bias is a benign term that suggests pre-held beliefs. Those beliefs are neither good nor bad inherently, they just *are*. Within the context of this guide to inclusiveness, “bias” refers to pre-held, influential beliefs about a particular kinship group (kinship group=people that share some commonality). When these beliefs become a problem is when they stand in the way of others feeling included. Bias is at the core of not being inclusive, and it takes an active effort to overcome this challenge.

Adapted from Thiederman’s book, Making Diversity Work, below are **6 tips toward becoming a more inclusive person by overcoming your own biases**. These can be strong tools to help others overcome their biases as well, and when used together make up a powerful system of becoming a more inclusive leader.

Tip 1: Become mindful of your biases

Most people have biases of one sort or another. It is inherent in the idea of culture that there be certain belief structures set up that are different from other cultures, and with this diversity of belief structures comes a diverse mix of biases.

It is important to not think that having a bias is the same as being a racist, sexist, homophobic, etc. These labels are seldom helpful, and they don’t take into account the natural diversity of opinion, background, upbringing, regional association, etc. Using these labels is just another way of being exclusive and demonstrating more bias.

If most people have biases of one sort or another, then the first step in overcoming bias is to recognize it, be mindful of it, and understand that it exists.

Ask yourself some important questions...

- Do I have any biases?
- When do my biases most often arise?
- What groups of people do I have strong biases about?
- Might I have other biases that I am not admitting?
- Do I feel guilty about my biases?

Tip 2: Identify the costs and benefits of your biases

Ask yourself some important questions...

- What am I gaining from having this bias?
- How is this bias benefiting me?
- Does this bias make me generally happier or more upset?
- Am I proud of this bias?

- What am I losing from this bias?
- How is this bias holding me back?
- Is this bias obstructing the mission of our group?
- If I didn't have this bias, how would things be easier?

Tip 3: Figure out where your bias comes from

Bias does not just appear out of thin air. It comes from experience, background, peers, family, media, big events, little events, encounters, trauma, socioeconomic level, exposure, shelter, etc. etc. etc. The pre-held beliefs you may have about a group of people are probably because of experiences that you have had, or the things that you have heard about a small amount of people that fall within the parameters of that group.

Try to identify where your biases come from so you have a better idea of how they have developed in your mind. Examining your own biases (and behaviors that result from these biases) can also help you understand the behaviors and beliefs of others.

Ask yourself some important questions...

- What biases might I have picked up from my close family members?
- What major experiences have I had that might have contributed to my bias?
- Where have I been/lived/traveled that may have contributed to my bias?

- What has the media communicated to me that I might have absorbed; adding to my bias?
- Do I have acquaintances that add credit or discredit my biases?
- What other experiences or influences in my life may contribute to biased beliefs?

Tip 4: Identify commonalities

Biases about groups of people are based on a predication that you do not belong in that group. In other words, the group of people for which you may hold a bias is DIFFERENT from you in some way, or in many ways.

To counteract the separation caused by the differences that you perceive, try to close the gap caused by bias through building a bridge with *commonalities* that you can observe.

Ask yourself one important question (and keep asking it until you've answered it many times)...

- What similarities do I share with these people for which I have some bias?

Tip 5: Commit to trying something new

Eradicating bias is a BIG job. This guide is not meant to be a silver bullet that stops bias in its readers once and for all. Instead, the job of halting your own bias must be handled in small chunks. Instead of focusing on STOPPING your biased beliefs, try focusing on STARTING *new* behavior.

Commit to trying a new belief out for a while. Just choose an inclusive statement, like: "That person is an individual, and just like me, wants to be healthy." Just try that small change out for a while, and see if your perspective is altered...even just a little. To eradicate bias, it must be replaced with inclusiveness.

Tip 6: Plan to avoid flare-ups

Bias is dangerous in its hidden form. When it is bottled up deep in your beliefs and just sits there festering it can cause stress, unhappiness, and can get in the way of productivity. However, it is VERY dangerous when it flares up into your words and actions.

If inclusiveness is a goal for your chapter, it is important that bias doesn't rear its ugly head in words and actions. This can cause major aggravation, sadness, and hurt. The first step toward an inclusive chapter is simply planning ahead to make sure your bias doesn't flare up out into the open air.

Once you have identified your bias – even the most minor bias – it is important to the health and well-being of your DBSA chapter that you simply plan ahead to avoid bias flare-ups. If you know that you might (*even an outside chance*) say something or do something that might be hurtful, identify what that might be, and plan to avoid it.

This is easier said than done, but the intention to avoid these flare-ups is a powerful tool toward an inclusive group.

Probably the most effective way to avoid bias flare-ups is through positive, healthy, honest *communication*. Talk to those about whom you may have bias, and learn more about them as *people...individuals*. Bias seems to disappear once someone becomes more than a member of a group, and shows themselves to be a simple human being... an individual.

Ideal State of Inclusiveness

The mission of the Depression and Bipolar Support Alliance is *to improve the lives of people living with mood disorders*. All of them.

Ideally, each chapter, each event, each program and each person involved in DBSA exudes the spirit of inclusiveness. All people are welcome to learn and gain support from the incredible individuals that make up the DBSA community. Ideally DBSA's local, national and international work reaches out into every community, every culture, and every person in need regardless of age, ethnicity, religion, sexual orientation, physical and mental ability, etc.

To achieve this ideal state of inclusiveness work must be done. Work must be done on the national level to promote the ideas, work must be done on the chapter level to reach out into local communities, and work must be done on the individual level to combat our individual biases.

Inclusiveness can be achieved, but it takes a commitment from each person, chapter and organization to make it so. Are you willing to commit?

Footnotes to Culture and Mental Health Facts

African American Community Mental Health Facts

Rates of Mental Illness

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American Indian and Alaska Native Communities Mental Health Facts

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4 CDC

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7 The Henry J. Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured

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Asian American and Pacific Islander Communities (AA/Pis) Mental Health Facts

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