

**Executive
Summary Contents**

- **Summary**
- [Main Findings](#)
- [Main Message](#)
- [Personal Health
Recommendations](#)
- [Organization of
Supplement and
Major Topics
Covered](#)
- [Chapter Summaries
& Conclusions](#)
- [References](#)
- [Report Home Page](#)

EXECUTIVE SUMMARY**MENTAL HEALTH: CULTURE,
RACE, AND ETHNICITY
A Supplement to
Mental Health: A Report of the
Surgeon General****DEPARTMENT OF HEALTH AND HUMAN
SERVICES
U.S. Public Health Service**

America is home to a boundless array of cultures, races, and ethnicities. With this diversity comes incalculable energy and optimism. Diversity has enriched our Nation by bringing global ideas, perspectives, and productive contributions to all areas of contemporary life. The enduring contributions of minorities, like those of all Americans, rest on a foundation of mental health.

Mental health is fundamental to overall health and productivity. It is the basis for successful contributions to family, community, and society. Throughout the lifespan, mental health is the wellspring of thinking and communication skills, learning, resilience, and self-esteem. It is all too easy to dismiss the value of mental health until problems appear. Mental health problems and illnesses are *real* and *disabling* conditions that are experienced by one in five Americans. Left untreated, mental illnesses can result in disability and despair for families, schools, communities, and the workplace. This toll is more than any society can afford.

This report is a Supplement to the first ever Surgeon General's Report on Mental Health, *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services [DHHS], 1999). That report provided extensive documentation of the scientific advances illuminating our understanding of mental illness and its treatment. It found a range of effective treatments for most mental disorders. The efficacy of mental health treatment is so well documented that the Surgeon General made this

single, explicit recommendation for all people: *Seek help if you have a mental health problem or think you have symptoms of a mental disorder.*

The recommendation to seek help is particularly vital, considering *the majority of people with diagnosable disorders, regardless of race or ethnicity, do not receive treatment.* The stigma surrounding mental illness is a powerful barrier to reaching treatment. People with mental illness feel shame and fear of discrimination about a condition that is as real and disabling as any other serious health condition.

Overall, the earlier Surgeon General's report provided hope for people with mental disorders by laying out the evidence for what can be done to prevent and treat them. It strove to dispel the myths and stigma that surround mental illness. It underscored several overarching points about mental health and mental illness (see box). Above all, it furnished hope for recovery from mental illness.

But in the Preface to the earlier report, the Surgeon General pointed out that all Americans do not share equally in the hope for recovery from mental illness:

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender (DHHS, 1999, p.vi).

Mental Health: A Report of the Surgeon General ***Themes of the Report***

- Mental health and mental illness require the broad focus of a public health approach.
- Mental disorders are disabling conditions.
- Mental health and mental illness are points on a continuum.
- Mind and body are inseparable.
- Stigma is a major obstacle preventing people from getting help.

Messages from the Surgeon General

- Mental health is fundamental to health.
- Mental illnesses are real health conditions.
- The efficacy of mental health treatments is well documented.

- A range of treatments exists for most mental disorders.

This Supplement was undertaken to probe more deeply into mental health disparities affecting racial and ethnic minorities. Drawing on scientific evidence from a wide-ranging body of empirical research, this Supplement has three purposes:

- To understand better the nature and extent of mental health disparities;
- To present the evidence on the need for mental health services and the provision of services to meet those needs; and
- To document promising directions toward the elimination of mental health disparities and the promotion of mental health.

This Supplement covers the four most recognized racial and ethnic minority groups in the United States. According to Federal classifications, African Americans (blacks), American Indians and Alaska Natives, Asian Americans and Pacific Islanders and white Americans (whites) are races. Hispanic American (Latino) is an ethnicity and may apply to a person of any race (U.S. Office of Management and Budget [OMB], 1978). For example, many people from the Dominican Republic identify their ethnicity as Hispanic or Latino and their race as black.

The Federal Government created these broad racial and ethnic categories in the 1970s for collecting census and other types of demographic information.¹ Within each of the broad categories, including white Americans, are many distinct ethnic subgroups. Asian Americans and Pacific Islanders, for example, include 43 ethnic groups speaking over 100 languages and dialects. For American Indians and Alaska Natives, the Bureau of Indian Affairs currently recognizes 561 tribes. African Americans are also becoming more diverse, especially with the influx of refugees and immigrants from many countries of Africa and the Caribbean. White Americans, too, are a profoundly diverse group, covering the span of immigration from the 1400's to the 21st century, and including innumerable cultural, ethnic, and social subgroups.

Each ethnic subgroup, by definition, has a common heritage, values, rituals, and traditions, but there is no such thing as a homogeneous racial or ethnic group (white or nonwhite). Though the data presented in this Supplement are often in the form of group averages, or sample means

(standard scientific practice for illustrating group differences and health disparities), it should be well noted that each racial or ethnic group contains the full range of variation on almost every social, psychological, and biological dimension presented. One of the goals of the Surgeon General is that no one will come away from reading this Supplement without an appreciation for the intrinsic diversity within each of the recognized racial or ethnic groups and the implications of that diversity for mental health.

Clearly, the four racial and ethnic minority groups that are the focus of this supplement are by no means the only populations that encounter disparities in mental health services. However, assessing disparities for groups such as people who are gay, lesbian, bisexual, and transgender or people with co-occurring physical and mental illnesses is beyond the scope of this Supplement. Nevertheless, many of the conclusions of this Supplement could apply to these and other groups currently experiencing mental health disparities.

¹ The Office of Management and Budget has recently separated Asian Americans from Native Hawaiians and other Pacific Islanders (OMB, 2000).

[Report HomePage](#) | [Next Page](#)

Executive Summary Contents

- [Summary](#)
- **Main Findings**
- [Main Message](#)
- [Personal Health
Recommendations](#)
- [Organization of
Supplement and
Major Topics
Covered](#)
- [Chapter Summaries
& Conclusions](#)
- [References](#)
- [Report Home Page](#)

Main Findings

Mental Illnesses are Real, Disabling Conditions Affecting All Populations, Regardless of Race or Ethnicity

Major mental disorders like schizophrenia, bipolar disorder, depression, and panic disorder are found worldwide, across all racial and ethnic groups. They have been found across the globe, wherever researchers have surveyed. In the United States, the overall annual prevalence of mental disorders is about 21 percent of adults and children (DHHS, 1999). This Supplement finds that, based on the available evidence, the prevalence of mental disorders for racial and ethnic minorities in the United States is similar to that for whites.

This general finding about similarities in overall prevalence applies to minorities living in the community.² It does not apply to those individuals in vulnerable, high-need subgroups such as persons who are homeless, incarcerated, or institutionalized. People in these groups have higher rates of mental disorders (Koegel et al., 1988; Vernez et al., 1988; Breakey et al., 1989; Teplin, 1990). Further, the rates of mental disorders are not sufficiently studied in many smaller racial and ethnic groups - most notably American Indians, Alaska Natives, Asian Americans, and Pacific Islander groups - to permit firm conclusions about overall prevalence within those populations.

This Supplement pays special attention to vulnerable, high-need populations in which minorities are overrepresented. Although individuals in these groups are known to have a high-need for mental health care, they often do not receive adequate services. This represents a critical public health concern, and this Supplement identifies as a course of action the need for earlier identification and care for these individuals within a coordinated and comprehensive service delivery system.

² Most epidemiological studies using disorder-based definitions of mental illness are conducted in community household surveys. They fail to include nonhousehold members, such as persons without homes or persons residing in institutions such as residential treatment centers, jails, shelters, and hospitals.

Striking Disparities in Mental Health Care Are

Found for Racial and Ethnic Minorities

This Supplement documents the existence of several disparities affecting mental health care of racial and ethnic minorities compared with whites:

- Minorities have less access to, and availability of, mental health services.
- Minorities are less likely to receive needed mental health services.
- Minorities in treatment often receive a poorer quality of mental health care.
- Minorities are underrepresented in mental health research.

The recognition of these disparities brings hope that they can be seriously addressed and remedied. This Supplement offers guidance on future courses of action to eliminate these disparities and to ensure equality in access, utilization, and outcomes of mental health care.

More is known about the disparities than the reasons behind them. A constellation of barriers deters minorities from reaching treatment. Many of these barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness (DHHS, 1999). But additional barriers deter racial and ethnic minorities; mistrust and fear of treatment, racism and discrimination, and differences in language and communication. The ability for consumers³ and providers to communicate with one another is essential for all aspects of health care, yet it carries special significance in the area of mental health because mental disorders affect thoughts, moods, and the highest integrative aspects of behavior. The diagnosis and treatment of mental disorders greatly depend on verbal communication and trust between patient and clinician. More broadly, mental health care disparities may also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status. The cumulative weight and interplay of all barriers to care, not any single one alone, is likely responsible for mental health disparities.

³ Although a number of terms identify people who use or have used mental health services (e.g., mental health consumer, survivor, ex-patient, client), the terms "consumer" and "patient" will be used interchangeably throughout this Supplement.

Disparities Impose a Greater Disability Burden on Minorities

This Supplement finds that racial and ethnic minorities collectively experience a greater disability burden from mental illness than do whites. This higher level of burden stems from minorities receiving less care and poorer quality of care, rather than from their illnesses being inherently more severe or prevalent in the community.

This finding draws on several lines of evidence. First, mental disorders are highly disabling for all the world's populations (Murray & Lopez, 1996; Druss et al., 2000). Second, minorities are less likely than whites to receive needed services and more likely to receive poor quality of care. By not receiving effective treatment, they have greater levels of disability in terms of lost workdays and limitations in daily activities. Further, minorities are overrepresented among the Nation's most vulnerable populations, which have higher rates of mental disorders and more barriers to care. Taken together, these disparate lines of evidence support the finding that minorities suffer a disproportionately high disability burden from unmet mental health needs.

The greater disability burden is of grave concern to public health, and it has very real consequences. Ethnic and racial minorities do not yet completely share in the hope afforded by remarkable scientific advances in understanding and treating mental disorders. Because of disparities in mental health services, a disproportionate number of minorities with mental illnesses do not fully benefit from, or contribute to, the opportunities and prosperity of our society. This preventable disability from mental illness exacts a high societal toll and affects all Americans. Most troubling of all, the burden for minorities is growing. They are becoming more populous, all the while experiencing continuing inequality of income and economic opportunity. Racial and ethnic minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.

[Previous Page](#) | [Next Page](#)

Executive Summary Contents

- ✦ [Summary](#)
- ✦ [Main Findings](#)
- ✦ **Main Message**
- ✦ [Personal Health Recommendations](#)
- ✦ [Organization of Supplement and Major Topics Covered](#)
- ✦ [Chapter Summaries & Conclusions](#)
- ✦ [References](#)
- ✦ [Report Home Page](#)

Main Message: Culture Counts

Culture and society play pivotal roles in mental health, mental illness, and mental health services. Understanding the wide-ranging roles of culture and society enables the mental health field to design and deliver services that are more responsive to the needs of racial and ethnic minorities.

Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999). It refers to the shared attributes of one group. Anthropologists often describe culture as a system of shared meanings. The term "culture" is as applicable to whites as it is to racial and ethnic minorities. The dominant culture for much of United States history focused on the beliefs, norms, and values of European Americans. But today's America is unmistakably multicultural. And because there are a variety of ways to define a cultural group (e.g., by ethnicity, religion, geographic region, age group, sexual orientation, or profession), many people consider themselves as having multiple cultural identities.

With a seemingly endless range of cultural subgroups and individual variations, culture is important because it bears upon what *all* people bring to the clinical setting. It can account for variations in how consumers communicate their symptoms and which ones they report. Some aspects of culture may also underlie culture-bound syndromes - sets of symptoms much more common in some societies than in others. More often, culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness. All cultures also feature strengths, such as resilience and adaptive ways of coping, which may buffer some people from developing certain disorders. Consumers of mental health services naturally carry this cultural diversity directly into the treatment setting.

Culture is a concept not limited to patients. It also applies to the professionals who treat them. Every group of professionals embodies a "culture" in the sense that they too have a shared set of beliefs, norms, and values. This is as true for health professionals as it is for other professional groups such as engineers and teachers. Any professional group's culture can be gleaned from the jargon they use, the orientation and emphasis in their textbooks, and from their mindset or way of looking at the world.

Health professionals in the United States and the institutions in which they train and practice are rooted in Western medicine which emphasizes the primacy of the human body in disease and the acquisition of knowledge through scientific and empirical methods. Through objective methods, Western medicine strives to uncover universal truths about disease: its causation, diagnosis, and treatment. Its achievements have become the cornerstone of medicine worldwide.

To say that physicians or mental health professionals have their own culture does not detract from the universal truths discovered by their fields. Rather, it means that most clinicians share a worldview about the interrelationship between body, mind, and environment informed by knowledge acquired through the scientific method. It also means that clinicians view symptoms, diagnoses, and treatments in ways that sometimes diverge from their clients' views, especially when the cultural backgrounds of the consumer and provider are dissimilar. This divergence of viewpoints can create barriers to effective care.

The culture of the clinician and the larger health care system govern the societal response to a patient with mental illness. They influence many aspects of the delivery of care, including diagnosis, treatments, and the organization and reimbursement of services. Clinicians and service systems, naturally immersed in their own cultures, have been ill-equipped to meet the needs of patients from different backgrounds and, in some cases, have displayed bias in the delivery of care. The main message of this Supplement is that "culture counts." The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services. Cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated - *and they do count*. Cultural differences must be *accounted for* to ensure that minorities, like all Americans, receive mental health care tailored to their needs.

[Previous Page](#) | [Next Page](#)

Executive Summary Contents

- [Summary](#)
- [Main Findings](#)
- [Main Message](#)
- **Personal Health
Recommendations**
- [Organization of
Supplement and
Major Topics
Covered](#)
- [Chapter Summaries
& Conclusions](#)
- [References](#)
- [Report Home Page](#)

Personal Health Recommendation: Seek Help

The efficacy of treatment is well documented, according to the main finding of *Mental Health: A Report of the Surgeon General*. There is evidence, described in this Supplement, that racial and ethnic minorities benefit from mental health treatment. And it is abundantly clear that good treatment is preferable to no treatment at all. Untreated mental disorders can have dire consequences - distress, disability, and, in some cases, suicide. Therefore, this Supplement underscores the personal health recommendation of the earlier report: *Every person, regardless of race or ethnicity, should seek help if they have a mental health problem or symptoms of a mental disorder.*

Individuals are encouraged to seek help from any source in which they have confidence. If they do not improve with the help received from the first source, they are encouraged to keep trying. At present, members of minority groups may experience limited availability of, and access to, culturally sensitive treatments. With time, access to these services should improve as a result of awareness of this problem and the courses of action identified in this Supplement. In the meantime, anyone who needs help must hear a simple, yet resounding, message of hope: *Treatment works and recovery is possible.*

[Previous Page](#) | [Next Page](#)