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Referral Patterns in Ethnic-Specific and Mainstream Programs for Ethnic Minorities and Whites

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The present study examined the referral patterns of 1,095 African, 2,168 Asian, 1,385 Hispanic, and 2,273 White Americans (18 years of age and older) in a public mental health system to determine whether group differences in help-seeking and referral patterns were related to participation in ethnic-specific versus mainstream programs. Results indicated that (a) ethnic minorities in both mainstream and ethnic-specific programs were more likely than Whites to have been referred by natural help-giving and lay referral sources (e.g., family or friends, health services, and social services) and (b) ethnic minorities in ethnic-specific programs were more likely than ethnic minorities in mainstream programs to have been referred by natural help-giving and lay referral sources if they were Asian and Hispanic Americans and self-referred if they were African Americans.

Since the 1960s, inequities in the delivery of mental health services to ethnic minority populations have been well documented. Such populations, particularly immigrant and refugee groups (Gong-Guy, 1987; Karno et al., 1987; Kinzie & Leung, 1993; Moscicki, Rae, Regier, & Locke, 1987), have been characterized as at high risk for psychological stress and mental health problems (Aldwin & Greenberger, 1987; Kessler et al., 1994; Ying, 1988); however, a pattern of low service use has been reported for African Americans (Hu, Snowden, Jerrell, & Nguyen, 1991; Padgett, Patrick, Burns, & Schlesinger, 1994), Asian Americans (Cheung & Snowden, 1990; Snowden & Cheung, 1990), and Hispanic Americans (Hough et al., 1987; S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

The literature suggests that this low service use may be a product of ethnic minority groups turning to culturally accepted alternatives. Nuclear and extended family members, as well as friends, physicians, clergy, and social services, are commonly viewed as important sources of support and assistance for African Americans (Neighbors, 1988; Taylor, Neighbors, & Broman, 1989), Asian Americans (S. Sue & Morishima, 1982; Uba, 1994), and Hispanic Americans (Martinez, 1993; Rogler, Malgady, & Rodriguez, 1989). Some ethnic minority groups are also known to seek out traditional folk healers and spiritualists for help with their problems (Garrison, 1977; Griffith & Baker, 1993; Ramos-McKay, Comas-Diaz, & Rivera, 1988; Uba, 1994).

Institutional barriers in the organization of professional services, however, may play a more critical role in preventing members of ethnic minorities from seeking the public mental health system (Martinez, 1993; Rogler et al., 1989). One of the most commonly cited barriers is the lack of bicultural and bilingual staff at existing mental health facilities (Keefe & Casas, 1980; Ruiz, 1990; S. Sue & Morishima, 1982). Because many traditional programs are staffed by personnel who cannot communicate with monolingual clients or have little or no understanding of ethnic minority cultures, it is not surprising that ethnic minority groups do not make greater use of available mental health programs (Rogler et al., 1989; D. W. Sue & Sue, 1990).

In consideration of these possible barriers, many mental health systems in the public sector began to develop ethnic-specific programs in ethnic minority communities to provide culturally responsive services that were similar or "parallel" in function to those in more traditional programs (S. Sue, 1977; Uba, 1982). Mental health programs that accommodate the multicultural and multilingual needs of ethnic minority groups are more likely to be the target of help seeking and to promote favorable patterns of service use in these ethnic minority communities (Dana, Behn, & Gonwa, 1992; Zane, Sue, Castro, & George, 1982).

Descriptive studies of ethnic-specific programs provide evidence to suggest that this hypothesis of institutional barriers may be accurate. In several instances, service use increased substantially after ethnic-specific programs were established in ethnic minority communities for Asian Americans (Hatanaka, Watanabe, & Ono, 1975; S. Sue & McKinney, 1975; True, 1975; Wong, 1977) and Hispanic Americans (Bloom, 1975; Fischman, Fraticelli, Newman, & Sampson, 1983; Flores, 1978; Organista, Muñoz, & González, 1994; Rodriguez, 1986; Trevino, Bruhn, & Bunce, 1979). Also, significant increases in treatment duration were

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found to be associated with client participation in ethnic-specific programs for African, Asian, and Hispanic Americans (O'Sullivan & Lasso, 1992; Takeuchi, Sue, & Yeh, 1995; Yeh, Takeuchi, & Sue, 1994). Despite these promising results, little is empirically known about the help-seeking and referral process that helped to direct prospective clients to these ethnic-specific programs.

Prospective clients who harbor negative feelings about traditional programs may seek ethnic-specific programs only because they anticipate a culturally and socially hospitable environment where interventions may be more responsive and sensitive to their special needs. Increased outreach efforts by bicultural and bilingual staff in ethnic-specific programs to community help-giving sources (e.g., family, friends, and churches) may also promote the greater accessibility and attractiveness of these programs to ethnic minority communities. No matter which pathways of help seeking and referral may be affected, the result would be to reduce the institutional barriers that exist between the traditional mental health system and ethnic minority communities.

This study investigated whether use of ethnic-specific versus mainstream programs was stimulated by increased access to the natural help-seeking and lay referral system in ethnic minority communities. The purpose of this article is twofold: (a) to identify group differences in the help-seeking and referral patterns of three ethnic minority groups (African, Asian, and Hispanic Americans) versus Whites in the public mental health system and (b) to determine whether these group differences in referral patterns are related to participation in ethnic-specific versus mainstream programs.

Two related hypotheses were tested. First, on the basis of previous help-seeking literature, it was predicted that ethnic minorities in ethnic-specific and mainstream programs would report a higher percentage of referrals from their natural help-seeking and lay referral system (e.g., family or friends, health services, and social services) than Whites in mainstream programs. Second, because of the special cultural orientation of ethnic-specific programs, it was predicted that ethnic minorities in these ethnic-specific programs would also report a higher percentage of referrals from their natural help-seeking and lay referral system than ethnic minorities in mainstream programs.

Method

Data Source

Data for the study were obtained from the Automated Information System (AIS) of the Department of Mental Health in Los Angeles County. Information from the AIS has been previously audited and verified by the county and state and used for data and financial management, revenue collection, client monitoring, and empirical research (Flaskerud & Akutsu, 1993; S. Sue et al., 1991).

The statistics in this study were based on a sample rather than the total client population of Los Angeles County, which provided services to more than 600,000 unduplicated clients in the 15-year period from 1973 to 1988. As a result of changes in the AIS, as well as the adoption of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; American Psychiatric Association, 1980) by the county system in 1983, this study examined only those clients who had entered the county system in the 5-year period from January 1983 to August 1988. Because Asian Americans constituted the smallest client group in the mental health system of Los Angeles County, a comparable number of African, Hispanic, and White Americans were randomly selected from the total client population to constitute the samples for this study. Once this procedure was completed, only those clients who had entered the county system for the first time were selected for the final sample to control for the possible effects of previous mental health experiences in the system. Given these procedures, the data may differ from values that would be obtained from a statistical analysis of the total client population of Los Angeles County.

Ethnic-specific and mainstream programs were identified in the following manner. Ethnic-specific programs were mental health programs that provided services to primarily a single ethnic minority group (at least 70% of the clients) and employed mostly staff and personnel who were of the same ethnic background as their client population (at least 70% of the staff). Mainstream programs were mental health programs that provided services to primarily White clients (at least 50% of the clients) and employed mostly White staff and personnel (at least 50% of the staff). Researchers who were familiar with the public mental health system were consulted to verify that these selected programs were ethnic specific in terms of the special characteristics outlined by Zane et al. (1982) and Dana et al. (1992).

Initially, eight client–agency groups were identified for this study; that is, there were four types of client ethnicity (African, Asian, Hispanic, and White) and two types of service agencies (ethnic specific and mainstream). However, few Whites had sought out ethnic-specific programs, and this client–agency group was excluded from the final sample in the study.

Clients

The sample consisted of 1,095 African, 2,168 Asian, 1,385 Hispanic, and 2,273 White American adults (18 years of age and older) who had received outpatient services in Los Angeles County between January 1983 and August 1988. With regard to demographic characteristics, the percentage of African American female clients (51.96%) was lower than the percentages of White (56.31%), Asian American (59.04%), and Hispanic American (60.72%) female clients, $\chi^2(3, N = 6{,}921) = 22.96$, $p < .001$. Whites ($M = 36.05$ years, $SD = 14.21$) and Asian Americans ($M = 35.66$ years, $SD = 13.10$) were older than Hispanic Americans ($M = 33.83$ years, $SD = 13.14$) and African Americans ($M = 33.27$ years, $SD = 12.22$), $F(3, 6917) = 16.13$, $p < .001$. Higher percentages of Asian Americans (38.19%) and Hispanic Americans (35.52%) than Whites (20.15%) and African Americans (16.90%) were married, $\chi^2(3, N = 6{,}921) = 284.37$, $p < .001$. Not surprisingly, higher percentages of Asian Americans (65.18%) and Hispanic Americans (47.51%) than African Americans (2.28%) and Whites (1.45%) spoke a non-English language as their primary language, $\chi^2(3, N = 6{,}921) = 2{,}721.63$, $p < .001$. Also, the percentage of African Americans (83.84%) of poverty status was higher than the percentages of Hispanic Americans (75.31%), Whites (74.84%), and Asian Americans (72.51%) of such status, $\chi^2(3, N = 6{,}921) = 52.31$, $p < .001$.

As for clinical characteristics, higher percentages of African Americans (22.01%) and Asian Americans (19.05%) than Whites (16.28%) and Hispanic Americans (12.06%) were diagnosed with a psychotic disorder, $\chi^2(3, N = 6{,}921) = 50.04$, $p < .001$. How-

ever, Asian Americans (M = 44.04, SD = 14.47) and Hispanic Americans (M = 43.86, SD = 13.92) had higher scores on the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976) at clinic admission than African Americans (M = 40.92, SD = 15.29) and Whites (M = 40.84, SD = 15.30), $F(3, 6917) = 25.53$, $p < .001$.

Procedure

At clinic admission, clients who sought services in the public mental health system were presented with standard forms to provide demographic, clinical, and financial information for clinic records and the AIS in Los Angeles County. Once these intake forms were completed, clinic staff reviewed the information and subsequently interviewed the clients to collect further information about their specific mental health needs and to ensure that the provided information was accurate and complete.

Results

The more than 300 categories of referral sources recorded in the AIS were divided into 6 broad categories for examination in this study: (a) self-referral, (b) referral by a family member or friend, (c) referral from a criminal justice program, (d) referral from a social service program, (e) referral from a health program (e.g., hospital or medical clinic) or private medical practitioner (e.g., nurse or physician), and (f) referral from a previous mental health program or private mental health practitioner (e.g., psychiatrist or psychologist). Table 1 provides the percentages of the six referral categories across the seven client–agency groups. Chi-square tests were performed to identify whether significant differences in these help-seeking and referral patterns were present between each ethnic minority group and Whites; an alpha level of .05 was used in these tests. Results of the analyses indicated significant group differences in referral patterns between (a) African Americans at ethnic-specific programs and African Americans and Whites at mainstream programs, $\chi^2(2, N = 3{,}368) = 113.07$, $p < .001$; (b) Asian Americans at ethnic-specific programs and Asian Americans and Whites at mainstream programs, $\chi^2(2, N = 4{,}441) = 886.71$, $p < .001$; and (c) Hispanic Americans at ethnic-specific programs and Hispanic Americans and Whites at mainstream programs, $\chi^2(2, N = 3{,}658) = 69.23$, $p < .001$.

Because significant differences in demographic and clinical characteristics were reported for these four ethnic groups, a series of simultaneous logistic regression analyses was performed; demographic, clinical, and referral categories served as independent variables. The purpose of these analyses was to determine whether significant differences in referral patterns would still be associated with participation at ethnic-specific versus mainstream programs after the contribution of demographic and clinical characteristics had been controlled. Because limited English ability could influence a client's decision to seek an ethnic-specific versus a mainstream program, primary language was also included as an independent variable for within-group comparisons of Asian and Hispanic Americans only. As a means of examining the predictive value of each referral category, the baseline group for comparison was alternated for each logistic regression analysis (per sample).

Table 2 shows the results of the logistic regression analyses in predicting African American versus White use of mainstream programs, African American use of ethnic-specific programs versus White use of mainstream programs, and African American use of ethnic-specific versus mainstream programs. African Americans in mainstream programs, in comparison with Whites in mainstream programs, were more likely to be (a) referred by family or friends, criminal justice services, health services, social services, or previous mental health services than self-referred and (b) referred by criminal justice or health services than self-referred or referred by family or friends or previous mental health services. African Americans in mainstream programs were also more likely to be younger, of poverty status, and diagnosed with a psychotic disorder than Whites in mainstream programs.

African Americans in ethnic-specific programs, in comparison with Whites in mainstream programs, were more likely to be (a) self-referred or referred by criminal justice services or health services than referred by family or friends or previous mental health services and (b) referred by criminal justice services than self-referred or referred by health services or social services. Also, African Americans in

Table 1
Percentages for Referral Categories by Ethnicity and Service Agency

Variable	White (M; n = 2,273)	African American		Asian American		Hispanic American	
		ES (n = 401)	M (n = 694)	ES (n = 1,057)	M (n = 1,111)	ES (n = 449)	M (n = 936)
Self	43.60	46.63	29.54	20.25	31.95	45.88	39.64
Family–friends	14.03	6.98	12.54	25.45	17.28	15.37	13.03
Criminal justice services	14.43	24.44	22.19	9.08	17.82	14.70	14.85
Health services	12.05	14.46	19.31	6.05	16.65	10.02	17.95
Social services	4.27	2.74	4.76	34.25	5.58	9.58	6.09
Previous mental health services	11.61	4.74	11.67	4.92	10.71	4.45	8.44

Note. M = mainstream programs; ES = ethnic-specific programs.

Table 2
Simultaneous Logistic Regression Analyses for Variables Predicting African American Use of Mainstream and Ethnic-Specific Programs

Variable	African American M vs. White M			African American ES vs. White M			African American ES vs. African American M		
	B	SE_B	β	*B*	SE_B	β	*B*	SE_B	β
Characteristics									
Gender[a]	−0.04	0.09	−.01	−0.08	0.11	−.02	−0.07	0.13	−.02
Marital status[b]	0.16	0.12	.03	−0.42	0.16	−.09*	−0.55	0.19	−.11**
Age	−0.02	0.00	−.14***	−0.01	0.00	−.06	0.01	0.00	.09*
Poverty status[c]	0.40	0.12	.09***	0.51	0.15	.12***	0.16	0.18	.03
Clinical diagnosis[d]	0.45	0.12	.10***	0.26	0.16	.05	−0.22	0.18	−.05
Admission Global Assessment Scale score	0.00	0.00	.02	0.02	0.00	.16***	0.02	0.00	.14***
Referral source comparison: self-referral[e]									
Family or friends	0.30	0.14	.06*	−0.74	0.21	−.14***	−0.96	0.24	−.16***
Criminal justice services	0.73	0.13	.15***	0.54	0.15	.11***	−0.21	0.17	−.05
Health services	0.88	0.13	.17***	0.10	0.17	.02	−0.79	0.19	−.16***
Social services	0.48	0.22	.05*	−0.59	0.33	−.06	−1.01	0.37	−.11**
Previous mental health services	0.37	0.15	.07*	−0.92	0.25	−.16***	−1.29	0.28	−.20***
Referral source comparison: family or friends[e]									
Criminal justice services	0.43	0.16	.09**	1.28	0.23	.26***	0.75	0.26	.17**
Health services	0.58	0.16	.11***	0.84	0.25	.15***	0.17	0.27	.04
Social services	0.18	0.24	.02	0.15	0.38	.02	−0.06	0.42	−.01
Previous mental health services	0.07	0.18	.01	−0.18	0.31	−.03	−0.34	0.34	−.05
Referral source comparison: criminal justice services[e]									
Health services	0.15	0.15	.03	−0.44	0.19	−.08*	−0.58	0.21	−.12**
Social services	−0.24	0.23	−.03	−1.12	0.34	−.12**	−0.80	0.38	−.09*
Previous mental health services	−0.35	0.17	−.06*	−1.46	0.27	−.25***	−1.08	0.29	−.17***
Referral source comparison: health services[e]									
Social services	−0.39	0.23	−.04	−0.68	0.35	−.07	−0.23	0.39	−.02
Previous mental health services	−0.50	0.17	−.09**	−1.02	0.28	−.17***	−0.51	0.30	−.08
Referral source comparison: social services[e]									
Previous mental health services	−0.11	0.24	−.02	−0.33	0.40	−.06	−0.28	0.44	−.04

Note. Concordant classifications were as follows: African American M vs. White M, 63.4%, $\chi^2(11, N = 2{,}967) = 128.67$, $p < .001$; African American ES vs. White M, 65.4%, $\chi^2(11, N = 2{,}674) = 107.02$, $p < .001$; and African American ES vs. African American M, 65.6%, $\chi^2(11, N = 1{,}095) = 79.73$, $p < .001$. M = mainstream programs; ES = ethnic-specific programs.
[a] 0 = male, 1 = female. [b] 0 = never married, 1 = married at some time. [c] 0 = above the federal standard for poverty, 1 = below or equal to the federal standard for poverty. [d] 0 = nonpsychotic disorder, 1 = psychotic disorder. [e] Baseline group.
* $p < .05$. ** $p < .01$. *** $p < .001$.

ethnic-specific programs were more likely to be of poverty status and to receive higher admission GAS scores than Whites in mainstream programs; however, they were less likely to be married.

African Americans in ethnic-specific programs, in comparison with African Americans in mainstream programs, were more likely to be self-referred or referred by criminal justice services than referred by other referral sources. In addition, African Americans in ethnic-specific programs were more likely to be older and to receive higher admission GAS scores than African Americans in mainstream programs; however, they were less likely to be married.

Table 3 shows the results of the logistic regression analyses in predicting Asian American use versus White use of mainstream programs, Asian American use of ethnic-specific programs versus White use of mainstream programs, and Asian American use of ethnic-specific versus mainstream programs. Asian Americans in mainstream programs, in comparison with Whites in mainstream programs, were more likely to be (a) referred by family or friends, criminal justice services, health services, social services, or previous mental health services than self-referred and (b) referred by family or friends, criminal justice services, health services, or social services than referred by previous mental health services. Asian Americans in mainstream programs were also more likely to be female, married,

Table 3
Simultaneous Logistic Regression Analyses for Variables Predicting Asian American Use of Mainstream and Ethnic-Specific Programs

Variable	Asian American M vs. White M			Asian American ES vs. White M			Asian American ES vs. Asian American M		
	B	SE_B	β	*B*	SE_B	β	*B*	SE_B	β
Characteristics									
Gender[a]	0.18	0.08	.05*	0.16	0.09	.04	0.07	0.12	.02
Marital status[b]	0.77	0.09	.18***	1.31	0.10	.32***	0.19	0.12	.05
Age	−0.02	0.00	−.14***	0.00	0.00	.02	0.01	0.00	.07*
Poverty status[c]	−0.09	0.09	−.02	0.21	0.10	.05*	0.17	0.13	.04
Primary language[d]							2.75	0.14	.72***
Clinical diagnosis[e]	0.71	0.10	.16***	0.29	0.14	.06*	−0.68	0.16	−.15***
Admission Global Assessment Scale score	0.00	0.00	.04	0.04	0.00	.30***	0.04	0.00	.29***
Referral source comparison: self-referral[f]									
Family or friends	0.52	0.11	.10***	1.55	0.12	.33***	0.94	0.16	.21***
Criminal justice services	0.51	0.12	.10***	0.58	0.15	.11***	−0.18	0.19	−.03
Health services	0.71	0.12	.13***	0.18	0.17	.03	−0.80	0.20	−.14***
Social services	0.60	0.18	.07***	2.97	0.15	.56***	2.16	0.20	.47**
Previous mental health services	0.19	0.13	.03	0.10	0.18	.02	−0.02	0.22	.00
Referral source comparison: family or friends[f]									
Criminal justice services	−0.01	0.14	.00	−0.97	0.15	−.18***	−1.12	0.20	−.21***
Health services	0.19	0.14	.04	−1.37	0.17	−.23***	−1.75	0.21	−.31***
Social services	0.08	0.19	.01	1.43	0.15	.27***	1.22	0.20	.27***
Previous mental health services	−0.32	0.15	−.06*	−1.45	0.18	−.23***	−0.96	0.23	−.14***
Referral source comparison: criminal justice services[f]									
Health services	0.20	0.14	.04	−0.39	0.20	−.07*	−0.63	0.23	−.11**
Social services	0.09	0.19	.01	2.40	0.18	.46***	2.34	0.23	.51***
Previous mental health services	−0.31	0.15	−.06*	−0.48	0.20	−.08*	0.16	0.25	.02
Referral source comparison: health services[f]									
Social services	−0.11	0.19	−.01	2.79	0.20	.53***	2.96	0.24	.65***
Previous mental health services	−0.52	0.15	−.09***	−0.08	0.22	−.01	0.78	0.26	.12**
Referral source comparison: social services[f]									
Previous mental health services	−0.41	0.20	−.07*	−2.87	0.20	−.46***	−2.18	0.26	−.32***

Note. Concordant classifications were as follows: Asian American M vs. White M, 64.1%, $\chi^2(11, N = 3{,}384) = 198.77, p < .001$; Asian American ES vs. White M, 81.8%, $\chi^2(11, N = 3{,}330) = 1{,}021.29, p < .001$; and Asian American ES vs. Asian American M, 87.6%, $\chi^2(12, N = 2{,}168) = 1{,}106.84, p < .001$. M = mainstream programs; ES = ethnic-specific programs.
[a] 0 = male, 1 = female. [b] 0 = never married, 1 = married at some time. [c] 0 = above the federal standard for poverty, 1 = below or equal to the federal standard for poverty. [d] 0 = English as the primary language, 1 = Asian language as the primary language. [e] 0 = nonpsychotic disorder, 1 = psychotic disorder. [f] Baseline group.
* $p < .05$. ** $p < .01$. *** $p < .001$.

younger, and diagnosed with a psychotic disorder than Whites in mainstream programs; however, they were less likely to be of poverty status.

Asian Americans in ethnic-specific programs were more likely than Whites in mainstream programs to be (a) referred by family or friends, criminal justice services, or social services than self-referred or referred by health services or previous mental health services; (b) referred by family or friends or social services than referred by criminal justice services; and (c) referred by social services than referred by family or friends. Also, Asian Americans in ethnic-specific programs were more likely to be married, to be of poverty status, to be diagnosed with a psychotic disorder, and to receive higher admission GAS scores than Whites in mainstream programs.

Asian Americans in ethnic-specific programs, in comparison with Asian Americans in mainstream programs, were more likely to be (a) self-referred or referred by family or friends, criminal justice services, social services, or previous mental health services than referred by health services; (b) referred by family or friends or social services than self-referred or referred by criminal justice services or previous mental health services; and (c) referred by social services than referred by family or friends. In addition,

Asian Americans in ethnic-specific programs were more likely to be older, to speak a non-English (Asian) language as their primary language, and to receive higher admission GAS scores than Asian Americans in mainstream programs; however, they were less likely to be diagnosed with a psychotic disorder.

Table 4 shows the results of the logistic regression analyses in predicting Hispanic American use versus White use of mainstream programs, Hispanic American use of ethnic-specific programs versus White use of mainstream programs, and Hispanic American use of ethnic-specific versus mainstream programs. Hispanic Americans in mainstream programs, in comparison with Whites in mainstream programs, were more likely to be (a) referred by criminal justice services, social services, or health services than referred by previous mental health services; (b) referred by social or health services than self-referred; and (c) referred by health services than referred by family or friends or criminal justice services. Hispanic Americans in mainstream programs were also more likely to be married, younger, and of poverty status than Whites in mainstream programs.

Hispanic Americans in ethnic-specific programs were more likely than Whites in mainstream programs to be (a)

Table 4
Simultaneous Logistic Regression Analyses for Variables Predicting Hispanic American Use of Mainstream and Ethnic-Specific Programs

Variable	Hispanic American M vs. White M			Hispanic American ES vs. White M			Hispanic American ES vs. Hispanic American M		
	B	SE_B	β	*B*	SE_B	β	*B*	SE_B	β
Characteristics									
Gender[a]	0.08	0.08	.02	0.39	0.12	.10***	0.24	0.13	.07
Marital status[b]	0.78	0.09	.18***	1.01	0.12	.24***	0.06	0.13	.02
Age	−0.02	0.00	−.15***	−0.01	0.00	−.09**	0.00	0.00	.03
Poverty status[c]	0.24	0.10	.06*	0.03	0.12	.01	−0.32	0.14	−.08*
Primary language[d]							0.72	0.13	.20***
Clinical diagnosis[e]	0.07	0.12	.01	−0.76	0.25	−.15**	−0.80	0.27	−.14**
Admission Global Assessment Scale score	0.00	0.00	.02	0.04	0.00	.29***	0.04	0.01	.27***
Referral source comparison: self-referral[f]									
Family or friends	0.11	0.12	.02	0.21	0.16	.04	0.28	0.19	.05
Criminal justice services	0.17	0.13	.03	0.44	0.17	.08**	0.23	0.19	.04
Health services	0.55	0.12	.10***	−0.09	0.19	−.01	−0.59	0.20	−.12**
Social services	0.47	0.18	.06**	0.76	0.21	.09***	0.34	0.23	.05
Previous mental health services	−0.21	0.14	−.04	−0.87	0.25	−.15***	−0.74	0.28	−.10**
Referral source comparison: family or friends[f]									
Criminal justice services	0.06	0.15	.01	0.23	0.20	.04	−0.05	0.23	−.01
Health services	0.44	0.15	.08*	−0.31	0.22	−.05	−0.87	0.24	−.17***
Social services	0.36	0.20	.04	0.55	0.24	.07*	0.06	0.27	.01
Previous mental health services	−0.32	0.17	−.05	−1.08	0.27	−.18***	−1.02	0.31	−.14***
Referral source comparison: criminal justice services[f]									
Health services	0.39	0.15	.07**	−0.53	0.22	−.09*	−0.82	0.24	−.16**
Social services	0.30	0.20	.04	0.33	0.24	.04	0.11	0.27	.02
Previous mental health services	−0.38	0.17	−.06*	−1.31	0.28	−.22***	−0.97	0.31	−.14**
Referral source comparison: health services[f]									
Social services	−0.08	0.20	−.01	0.86	0.26	.10***	0.93	0.28	.13***
Previous mental health services	−0.76	0.16	−.13***	−0.78	0.29	−.13**	−0.16	0.32	−.02
Referral source comparison: social services[f]									
Previous mental health services	−0.68	0.21	−.12**	−1.63	0.31	−.28***	−1.08	0.34	−.15**

Note. Concordant classifications were as follows: Hispanic American M vs. White M, 62.3%, $\chi^2(11, N = 3{,}209) = 135.51$, $p < .001$; Hispanic American ES vs. White M, 72.8%, $\chi^2(11, N = 2{,}722) = 261.61$, $p < .001$; and Hispanic American ES vs. Hispanic American M, 70.4%, $\chi^2(12, N = 1{,}385) = 174.57$, $p < .001$. M = mainstream programs; ES = ethnic-specific programs.

[a] 0 = male, 1 = female. [b] 0 = never married, 1 = married at some time. [c] 0 = above the federal standard for poverty, 1 = below or equal to the federal standard for poverty. [d] 0 = English as the primary language, 1 = Spanish as the primary language. [e] 0 = nonpsychotic disorder, 1 = psychotic disorder. [f] Baseline group.

* $p < .05$. ** $p < .01$. *** $p < .001$.

self-referred or referred by family or friends, criminal justice services, health services, and social services than referred by previous mental health services; (b) referred by criminal justice services or social services than self-referred or referred by health services; and (c) referred by social services than referred by family or friends. Also, Hispanic Americans in ethnic-specific programs were more likely to be female, married, and younger and to receive higher admission GAS scores than Whites in mainstream programs; however, they were less likely to be diagnosed with a psychotic disorder.

Hispanic Americans in ethnic-specific programs, in comparison with Hispanic Americans in mainstream programs, were more likely to be self-referred or referred by family or friends, criminal justice services, or social services than referred by health services or previous mental health services. In addition, Hispanic Americans in ethnic-specific programs were more likely to speak a non-English (Spanish) language as their primary language and to receive higher admission GAS scores than Hispanic Americans in mainstream programs; however, they were less likely to be of poverty status or diagnosed with a psychotic disorder.

Discussion

Results from this study show significant differences in the referral patterns in ethnic-specific versus mainstream programs for ethnic minority populations. African Americans in ethnic-specific programs were more likely to have been self-referred or referred by criminal justice services than African Americans in mainstream programs. In fact, self-referrals were reported by 47% of the African Americans in ethnic-specific programs but less than 30% of the African Americans in mainstream programs. In contrast, Asian Americans in ethnic-specific programs were more likely to have been referred by family or friends and social services than Asian Americans in mainstream programs. Of significance is the finding that referrals from social services were reported by 34% of the Asian Americans in ethnic-specific programs but less than 6% of the Asian Americans in mainstream programs. Interestingly, Hispanic Americans in ethnic-specific programs also were more likely to have been self-referred or referred by family or friends, criminal justice services, or social services than Hispanic Americans in mainstream programs. Taken as a whole, these results suggest that, for Asian and Hispanic Americans, involvement in lay referral networks and community-based programs is likely to precede entry into the public mental health system and that self-referral is a more likely path of entry for African Americans. These referred patterns were especially pronounced in ethnic-specific programs.

Not surprisingly, Asian and Hispanic Americans reporting a non-English language as their primary language were more likely to have sought ethnic-specific programs. This is particularly important because most Asian and Hispanic immigrants and refugees who have recently entered the United States have limited English skills and, therefore, require bilingual services from a mental health program. At the same time, however, language preference alone could not explain the differences observed in these referral patterns; such differences persisted after the effect for language had been controlled.

With regard to practice implications, these results suggest that mental health providers may be able to facilitate service use among prospective clients by targeting outreach efforts to natural help-giving and lay referral sources in ethnic minority populations. However, such attempts alone will probably fail to motivate and direct help-seeking responses from ethnic minority groups unless concurrent efforts are made to establish more culturally relevant and appropriate programs in ethnic minority communities.

The present study makes a significant contribution to a growing body of literature on ethnic-specific programs. Many of these recent studies have focused on treatment duration and outcome in ethnic-specific programs (Takeuchi et al., 1995; Yeh et al., 1994; Zane, Hatanaka, Park, & Akutsu, 1994); however, this study is unique because it provides insight into the possible relationship between referral patterns and service use of ethnic-specific and mainstream programs in the public sector. Similarly, other studies (e.g., Flaskerud & Akutsu, 1993) are beginning to provide some evidence to suggest that ethnic minorities in ethnic-specific programs may seek psychological care for different mental health conditions than ethnic minorities and Whites in mainstream programs. All of these results must be considered in attempts to explain how the development of ethnic-specific programs may promote greater service use and effectiveness of service delivery to ethnic minority communities.

Invariably, the critical question—whether or not ethnic-specific programs are more effective than other programs—cannot be fully addressed with available research. More empirical work, particularly in the areas of financing and organization, staffing, treatment strategies, and practice orientation, must be completed if there is to be a better understanding of the significant contribution of ethnic-specific programs. Subsequent investigations must also begin to focus on the adequacies of theories underlying these special treatment programs, the validity of assessing treatment effects, and the strength and integrity of service delivery to ethnic minority populations.

The functioning of ethnic-specific programs is especially important to consider in light of the current reform of many public mental health systems. Service system reorganization, often featuring managed care and capitation, has occurred already in many places and is continuing to take place on an ever-widening scale. There is a need for empirical evidence demonstrating the continued importance of minority-focused programs. In a nation that is becoming more heterogeneous in its cultural and ethnic diversity, mental health systems will have to rethink their mission and reconsider their mix of clinical services and programs to better serve the special needs of a multicultural population.

References

Aldwin, C., & Greenberger, E. (1987). Cultural differences in the predictors of depression. *American Journal of Community Psychology, 15,* 789–813.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

Bloom, B. (1975). *Changing patterns of psychiatric care.* New York: Human Sciences Press.

Cheung, F., & Snowden, L. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal, 26,* 277–291.

Dana, R. H., Behn, J. D., & Gonwa, T. (1992). A checklist for the examination of cultural competence in social service agencies. *Research on Social Work Practice, 2,* 220–233.

Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The Global Assessment Scale. *Archives of General Psychiatry, 33,* 766–771.

Fischman, G., Fraticelli, B., Newman, D. E., & Sampson, L. M. (1983). Day-treatment programs for the Spanish-speaking: A response to underutilization. *International Journal of Social Psychiatry, 29,* 215–219.

Flaskerud, J., & Akutsu, P. D. (1993). Significant influence of participation in ethnic-specific programs on clinical diagnosis for Asian Americans. *Psychological Reports, 72,* 1228–1230.

Flores, J. L. (1978). The utilization of a community mental health service by Mexican Americans. *International Journal of Social Psychiatry, 24,* 271–275.

Garrison, V. (1977). The "Puerto Rican syndrome" in psychiatry and espiritismo. In V. Crapanzano & V. Garrison (Eds.), *Case studies in spirit possession* (pp. 383–449). New York: Wiley.

Gong-Guy, E. (1987). *California Southeast Asian mental health needs assessment.* Oakland, CA: Asian Community Mental Health Services.

Griffith, E. E. H., & Baker, F. M. (1993). Psychiatric care of African Americans. In A. C. Gaw (Ed.), *Culture, ethnicity, and mental illness* (pp. 147–173). Washington, DC: American Psychiatric Press.

Hatanaka, H. K., Watanabe, W. Y., & Ono, S. (1975). The utilization of mental health services by Asian Americans in Los Angeles. In W. H. Ishikawa & N. H. Archer (Eds.), *Delivery of services in Pan Asian communities* (pp. 33–39). San Diego, CA: San Diego Pacific Asian Coalition Mental Health Training Center, San Diego State University.

Hough, R. L., Landsverk, J. A., Karno, M., Burnam, M. A., Timbers, D. M., Escobar, J. I., & Regier, D. A. (1987). Utilization of health and mental health services by Los Angeles Mexican Americans and non-Hispanic Whites. *Archives of General Psychiatry, 44,* 702–709.

Hu, T., Snowden, L. R., Jerrell, J. M., & Nguyen, T. D. (1991). Ethnic populations in public mental health: Services choice and level of use. *American Journal of Public Health, 81,* 1429–1434.

Karno, M., Hough, R. L., Burnam, M. A., Escobar, J. I., Timbers, D. M., Santana, F., & Boyd, J. H. (1987). Lifetime prevalence of specific psychiatric disorders among Mexican Americans and non-Hispanic Whites in Los Angeles. *Archives of General Psychiatry, 44,* 695–701.

Keefe, S. E., & Casas, J. M. (1980). Mexican Americans and mental health: A selected review and recommendations for mental health service delivery. *American Journal of Community Psychology, 8,* 303–326.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51,* 8–19.

Kinzie, J. D., & Leung, P. K. (1993). Psychiatric care of Indochinese Americans. In A. C. Gaw (Ed.), *Culture, ethnicity, and mental illness* (pp. 281–304). Washington, DC: American Psychiatric Press.

Martinez, C., Jr. (1993). Psychiatric care of Mexican Americans. In A. C. Gaw (Ed.), *Culture, ethnicity, and mental illness* (pp. 431–466). Washington, DC: American Psychiatric Press.

Moscicki, E. K., Rae, D., Regier, D. A., & Locke, B. Z. (1987). The Hispanic Health and Nutrition Examination Survey: Depression among Mexican Americans, Cuban Americans, Puerto Ricans. In M. Gaviria & J. D. Arana (Eds.), *Health and behavior: Research agenda for Hispanics* (Simon Bolivar Research Monograph No. 1, pp. 145–159). Chicago: University of Illinois at Chicago.

Neighbors, H. W. (1988). The help-seeking behavior of Black Americans: A summary of findings from the National Survey of Black Americans. *Journal of the National Medical Association, 80,* 1009–1012.

Organista, K. C., Muñoz, R. F., & González, G. (1994). Cognitive behavioral therapy for depression in low-income and minority medical outpatients: Description of a program and exploratory analyses. *Cognitive Therapy and Research, 18,* 241–259.

O'Sullivan, M. H., & Lasso, B. (1992). Community mental health services for Hispanics: A test of the culture compatibility hypothesis. *Hispanic Journal of Behavioral Sciences, 14,* 455–468.

Padgett, D. K., Patrick, C., Burns, B. J., & Schlesinger, H. J. (1994). Ethnicity and the use of outpatient mental health services in a national insured population. *American Journal of Public Health, 84,* 222–226.

Ramos-McKay, J. M., Comas-Diaz, L., & Rivera, L. A. (1988). Puerto Ricans. In L. Comas-Diaz & E. E. H. Griffith (Eds.), *Clinical guidelines in cross-cultural mental health* (pp. 204–232). New York: Wiley.

Rodriguez, O. (1986). Overcoming barriers to services among chronically mentally ill Hispanics: Lessons from the Project COPA evaluation. *Research Bulletin, 9*(1), Hispanic Research Center, Fordham University, New York.

Rogler, L. H., Malgady, R. G., & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research.* Malabar, FL: Krieger.

Ruiz, D. (1990). *Handbook of mental health and mental disorder among Black Americans.* Westport, CT: Greenwood Press.

Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45,* 347–355.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different.* New York: Wiley.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32,* 616–624.

Sue, S., Fujino, D., Hu, L., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59,* 533–540.

Sue, S., & McKinney, H. (1975). Asian Americans in the community mental health care system. *American Journal of Orthopsychiatry, 45,* 111–118.

Sue, S., & Morishima, J. (1982). *The mental health of Asian Americans.* San Francisco: Jossey-Bass.

Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health, 85,* 638–643.

Taylor, R. J., Neighbors, H. W., & Broman, C. L. (1989). Evaluation by Black Americans of the social service encounter during a serious personal problem. *Social Work, 34,* 205–211.

Trevino, F. M., Bruhn, J. G., & Bunce, H., III. (1979). Utilization of community mental health services in a Texas-Mexico border city. *Social Science and Medicine, 13,* 331–334.

True, R. H. (1975). Mental health services in a Chinese American community. In W. Ishikawa & N. H. Archer (Eds.), *Delivery of services in Pan Asian communities* (pp. 15–22). San Diego, CA: San Diego Pacific Asian Coalition Mental Health Training Center, San Diego State University.

Uba, L. (1982). Meeting the mental health needs of Asian Americans: Mainstream or segregated services. *Professional Psychology, 13,* 215–222.

Uba, L. (1994). *Asian Americans: Personality patterns, identity, and mental health.* Westport, CT: Greenwood Press.

Wong, N. (1977, May). *Psychiatric education and training of Asian American psychiatrists.* Paper presented at the meeting of the American Psychiatric Association, Toronto, Ontario, Canada.

Yeh, M., Takeuchi, D. T., & Sue, S. (1994). Asian-American children treated in the mental health system: A comparison of parallel and mainstream outpatient service centers. *Journal of Clinical Child Psychology, 23,* 5–12.

Ying, Y. (1988). Depressive symptomatology among Chinese-Americans as measured by the CES-D. *Journal of Clinical Psychology, 44,* 739–746.

Zane, N., Hatanaka, H., Park, S., & Akutsu, P. D. (1994). Ethnic-specific mental health services: Evaluation of the parallel approach for Asian-American clients. *Journal of Community Psychology, 22,* 68–81.

Zane, N., Sue, S., Castro, F. G., & George, W. (1982). Service system models for ethnic minorities. In L. R. Snowden (Ed.), *Reaching the underserved: Mental health needs of neglected populations* (pp. 229–258). Beverly Hills, CA: Sage.

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