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# Ethnic Minority Mental Health Services: Current Research and Future Conceptual Directions

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Since the 1970s, the United States has witnessed a massive transformation in the size and composition of its ethnic minority populations. This diversification of the American populace has occurred primarily through extensive immigration of people from such countries as Mexico, Puerto Rico, Cuba, China, Taiwan, Korea, and the Philippines. Refugees from Haiti, Vietnam, Laos, and Cambodia have also helped to reshape the demographic contour of the United States. A few of these changes have been subtle and gradual; others have been more dramatic. Regardless of the speed at which change has occurred, the implications of this transformation have been profound. Where once social scientists and policymakers confined the complex issue of race and ethnicity to African Americans and American Indians, this massive demographic conversion has caused broader challenges to traditional ideas. In terms of racial conflict, for example, the insurrection in Los Angeles in April 1992 represents a distinct contrast to the Watts rebellion 27 years prior. After the events in Watts during the summer of 1965, outrage and concern centered on the social, political, and economic equity of African Americans compared to White Americans. In 1992 the social relations and well-being of other ethnic groups, such as Latino Americans and Asian Americans, were seen as equally important to this complex dialogue.

The changing demography of the United States has turned the attention of service providers and policymakers to an increasingly important issue: How can we provide mental health (and other) services that are responsive to the needs of ethnic minority groups? The question is by no means novel. Despite some remarkable changes in public mental health care over the past three decades, one fact has remained constant: Ethnic minorities in the United States have failed to receive adequate mental health care. Although the specifics vary by group, research indicates that the mental health needs of ethnic minorities are largely unmet. Moreover, when services are available, they are often inappropriate. It is also evident that current patterns in research and professional

training and education serve to perpetuate these tendencies (Vega and Murphy, 1990, p. 1).

For decades the issue of "culturally appropriate services" has been relegated to the margins of mental health reform. In a sense, the current attention to issues of cultural diversity among "mainstream" service systems is gratifying. Ironically, however, widespread public attention to multicultural issues arises at a point where public resources and commitment to reform have ebbed. The intellectual and financial resources that have driven reform in community mental health for the previous three decades appear to be dwindling rapidly. Federal leadership has abated, biomedical and psychopharmacological research has become de rigueur—much to the detriment of "culturally sensitive" community psychiatry—and the training of mental health professionals continues "in a decidedly 'traditional' mode" (Vega and Murphy, 1990, p. 1).

A number of factors have contributed to the demise of mental health reform in the United States. Burgeoning political conservatism, tension among professionals, inadequate theories, confusion about goals and methods, inadequate training, and lack of funding have all played a role (Vega and Murphy, 1990, p. 16). In-depth analysis of these issues is beyond the scope of this chapter. However, some attention to the history and context of reform as they affect the future of multicultural mental health services is necessary to avoid repetition of past problems. This chapter reviews what is currently known about the use of mental health services among ethnic minorities and some past attempts to remedy the problems and overcome the obstacles when serving these populations.

Before beginning the main body of this chapter, a brief word on terminology may be wise. Given the relative recency of systematic research on ethnic minority mental health issues, a number of terms have been used to categorize ethnic collectives. For example, the preference for the term "Black" over "African American" or vice versa can create heated discussion from one perspective or another. Despite the controversies that can revolve around ethnic labels, the authors have chosen to refer to the major groups as "African American," "Asian American," "Latino American," "American Indian," and "Alaska Native." The authors acknowledge that these labels are most useful for political or social research convenience, but the terms also capture a sense of a group's historical connectedness to geographic regions and embrace a general sense of social and cultural distinctiveness. The authors also refer to these collectives as "ethnic minority" groups for virtually the same reason. First, the term "ethnic" conveys that a collective has a unique culture and ethnic identity. Second, the term "minority" refers to the fact these groups hold less political, economic, and social power in the United States than White Americans.

## Ethnic Minorities and Mental Health Services

### *Growth of Minority Populations*

It is estimated that by early in the next century about one-third of the population in the United States will consist of racial and ethnic minority groups (Jones,

1991). Some cities, such as New York and Los Angeles, already surpass this predicted proportion. In 1990 the U.S. Census estimated the resident population at 249 million people, representing a 9.8 percent increase over the population in 1980.[1] The West and South showed the greatest population growth, at 22 percent and 13 percent, respectively; growth in the Northeast (3 percent) and Midwest (1 percent) was well below the national rate of increase. Despite the continued movement of the population to the West, the South still had the largest proportion (35 percent) of the resident population of any geographic region. By comparison, the other regions had relatively similar percentages of the U.S. resident population; Northeast (20 percent), West (21 percent), and Midwest (24 percent).

As with other recent censuses,[2] African Americans comprised the largest ethnic minority group, with 12 percent of the U.S. population. However, the rate of increase of the African American population has steadily declined from 1960 (20 percent) to 1990 (13 percent). More than half of all African American residents (53 percent) live in the South, and only 9 percent live in the Northeast. The remaining 38 percent of African Americans are nearly equally divided between the West and Midwest. Although New York, California, and Texas had African American populations exceeding 2 million residents in 1990, the states with the highest proportion of African Americans were in the South, with Mississippi the highest at 36 percent.

The Hispanic origin[3] population in the United States has shown a consistent increase over the last three decades. In 1960 the Hispanic origin population made up 4.5 percent of the U.S. total, and this proportion doubled to 9.0 percent in 1990. Forty-five percent of the Hispanic origin population resided in the West. Most of the Hispanic population lived in California and Texas. Nearly 7.7 million Hispanics resided in California, which was more than the *total* population in all but nine states. In addition to California and Texas, New York and Florida also had Hispanic origin populations exceeding 1 million residents. The issue of racial and ethnic categories is discussed later in the chapter. Suffice it to say that the Hispanic label subsumes a number of disparate ethnic groups who reside in different parts of the country. For example, Cubans are predominant in Florida, Mexicans in California, and Puerto Ricans in New York.

Over the last two decades, Asian Americans and Pacific Islanders have become a growing presence in the United States. In 1980 the population of Asian Americans exceeded 3.7 million, more than doubling the 1.5 million figure in 1970. By 1990 the population nearly doubled again, exceeding 7.1 million. More than half (56 percent) of the Asian and Pacific Islanders live in the West. The ethnic groups that comprise the category "Asians and Pacific Islanders" are diverse in terms of cultural background, country of origin, and

[1]The U.S. Census data reported in this section come primarily from *Race and Hispanic Origin* (U.S. Department of Commerce, 1991). Other materials used to support these figures are cited separately in the narrative.

[2]Prior to 1970 the U.S. Census combined all ethnic minority groups into a non-White category.

[3]The U.S. Census reports figures for "people of Hispanic origin," which includes Whites and non-Whites.

reasons for coming to the United States. For example, more than 20 ethnic groups, who may speak one of more than 30 languages, are included in the Asian American category (O'Hare and Felt, 1991). The three largest Asian American ethnic groups are Chinese, Japanese, and Filipinos. Koreans and Southeast Asians (e.g., Vietnamese, Cambodians, Laotians) also comprise a significant number in the Asian American population. The three largest groups among Pacific Islanders are Native Hawaiians, Samoans, and Chamorros (Guamanians) (Asian Week, 1991).

The American Indian and Alaska Native population make up less than 1 percent of the U.S. resident population (0.8 percent). Between 1970 and 1980 the American Indian and Alaska Native population nearly doubled to 1.5 million; and between 1980 and 1990 the population grew 37.9 percent to almost 1.96 million. Nearly half of this population (48 percent) lived in the West, with Oklahoma, California, Arizona, and New Mexico having populations of more than 100,000. American Indians and Alaska Natives are a culturally heterogeneous group, consisting of more than 250 federally recognized tribes and at least 65 nonfederally recognized communities, in addition to 209 Alaska Native villages (Manson et al., 1987). Moreover, some researchers estimate that about half of the American Indians and Alaska Natives live in urban areas, and half live in rural areas or on reservations (Manson et al., 1987); others estimate that one-third of American Indians and Alaska Natives live in urban areas, one-third in rural areas or on reservations, and one-third move back and forth between urban and rural areas and the reservation (Yates, 1987).

### *Prevalence of Mental Disorders*

When planning mental health services, planners and researchers have required some estimate of the number of people who suffer from emotional and psychological problems. Despite this seemingly moderate request, much of the empirical research on minority mental health issues has been consumed with issues surrounding the accurate derivation of indicators of psychiatric need for mental health services. As with the U.S. population in general, treatment data drawn from clinic and hospital records have historically been used to estimate the prevalence of mental health problems in ethnic minority communities. The underlying assumption behind the use of treatment statistics is that most people who have a mental health problem eventually seek mental health care voluntarily or involuntarily. Archival data from clinic and hospital records have the advantage of being more accessible and less costly to collect than community survey data. The use of treatment data has been especially popular for estimating prevalence and need among ethnic minority populations, where the costs associated with sampling rare (or small) populations and measuring mental disorders across culturally distinct groups are relatively high. Data drawn from treatment facilities can provide an accumulation of large samples of ethnic minority consumers (especially if the data are amassed over time) and easily codified clinical data. Epidemiologists note, however, that service use is an unreliable indicator of actual prevalence of need. It appears to be especially so

for ethnic minority groups, many of whom experience barriers to service access and use.

The early studies using treatment data showed that African Americans have been overrepresented and Asian Americans underrepresented in mental hospitals. The evidence for Latino American populations is less clear. Lopez (1981) reviewed 17 studies on the use of inpatient care among Mexican Americans. In 12 of these studies, Mexican Americans were underrepresented in psychiatric hospitals; the remaining five studies showed proportional or overrepresentation. More recent data suggest that the patterns for Asian Americans and African Americans continue into the present. When analyzing national data from 1980, Snowden and Cheung (1990) found that White Americans were admitted into inpatient hospitals at a rate of 550 per 100,000 civilian population. African Americans (931.8/100,000) and American Indians and Alaska Natives (818.7/100,000) had admission rates considerably higher than that of White Americans. Asian Americans and Pacific Islanders (268.1) and adults of Hispanic origin (451.4) had rates lower than that of White Americans. Snowden and Cheung (1990) found similar patterns for the use of community outpatient services.

Aside from issues pertinent to reliability and validity of clinic record data, treatment statistics give a biased estimate when used to appraise the prevalence of mental disorders in the community. As more community surveys have been conducted, the results indicate that treatment statistics severely underestimate the level of need for mental health services in the community. Link and Dohrenwend (1980), in a review of 11 studies between 1917 and 1983, found that a median 26.7 percent of the people with a clinical disorder actually received mental health treatment. With advances in survey research, community psychiatric epidemiological studies became a realistic alternative to the analysis of treatment data to establish the prevalence of mental illness in the community.

Despite the promise and appeal of survey research, only a limited number of community studies have been conducted on ethnic minority groups. The few studies that have been conducted tend to focus on the unique characteristics and needs within different ethnic minority groups. For example, investigators have emphasized the understanding of risk factors for alcohol abuse, suicide, depression, and the co-occurrence of disorders—problems that have had a devastating impact in American Indian and Alaskan Native communities (Manson et al., 1987; O'Nell, 1989; Maser and Dinges, 1992–93). Asian American and Latino American researchers have tended to concentrate on issues that revolve around immigration and refugee status, such as acculturation, ethnic identity, and adaptation (Sue and Morishima, 1982; Vega and Rumbaut, 1991). Studies in African American communities have tended to focus on subgroup differences, such as geography, gender, social class, marital status, and religion (Neighbors, 1990). In general, the existing studies vary in terms of the measures used, geographic units, and sampling strategies, making comparisons across investigations difficult (see Vega and Rumbaut, 1991, for an excellent review). Although these methodological problems hamper the ability to make clear generalizations about the level of mental health problems in different ethnic mi-

nority communities, two general points should be emphasized concerning this disparate literature. The first observation compares treatment and community prevalence estimates, and the second considers an argument about the nature of psychopathology among ethnic minority groups.

First, the available epidemiological evidence shatters some of the conclusions perpetuated by treatment statistics, especially among African Americans and Asian Americans. As mentioned earlier, one of the consistent findings from the early treatment studies is that African Americans are overrepresented in both inpatient and outpatient mental health services. This finding has led to speculation that African Americans have a higher rate of psychopathology than White Americans, but community studies do not support a consistent pattern of higher psychopathology among African Americans. In fact, about half of the studies in recent years have shown that African Americans had a higher rate of psychopathology and the other half of the studies reported that the rate of psychopathology was either lower or comparable to that in White Americans (Dohrenwend and Dohrenwend, 1969; Vega and Rumbaut, 1991). Somervell and colleagues (1989), analying the Epidemiologic Catchment Area program data, found that African Americans had rates of clinical measures of major depression comparable to those in White Americans.

Community studies also contradict treatment data when the rates of psychopathology among Asian Americans are examined. It is well established that Asian Americans make less use of community mental health services than White Americans (see Leong, 1986, for a review). Two competing hypotheses have been advanced to explain this finding. Some researchers argue that Asian Americans have a lower rate of psychopathology than White Americans, whereas others speculate that Asian Americans have a higher rate of psychiatric problems but access barriers to clinics, cultural stigma against mental illness, and culture-specific help-seeking behaviors operate to reduce hospital admissions (Sue and Morishima, 1982). Although the number of studies conducted on Asian Americans have been limited and were based on problematic methodological procedures (e.g., sampling based on snowball procedures or inaccurate registries; inappropriate research measures), the available literature suggests that some Asian American ethnic groups may have a higher rate of psychopathology than White Americans (Kuo, 1984; Takeuchi and Adair, 1992). Moreover, there appears to be a great deal of variance within the Asian American category (Meinhart et al., 1985–1986; Rumbaut, 1985, 1989; Takeuchi and Adair, 1992).

Obviously, deriving accurate estimates about the prevalence of psychiatric problems among ethnic minority groups has serious implications for mental health services. If, for example, community surveys indicate that a large proportion of Asian Americans have a mental health problem, but treatment data show that Asian Americans are underrepresented in hospitals and community clinics, mental health programs must examine alternatives that would reach this population. Although community epidemiological studies are recognized to produce more reliable estimates of psychiatric problems, cost and methodological problems have hindered the conduct of large-scale community studies in

minority communities (Becker et al., 1992). In recent years, investigators have spent much energy on understanding how culture influences the definition, and consequently the measurement, of mental illness. Without special attention to these issues, the validity of prevalence estimates is called into question. Moreover, the conceptualization and measurement of mental health and illness shapes the way services are delivered in ethnic minority communities. The authors return to this issue in the next section.

The second observation concerns the overlap between socioeconomic status and ethnic minority group membership. There is considerable debate over the extent to which differences in prevalence rates can be attributed to ethnic minority or social class phenomena. Two theoretical perspectives are usually advanced to explain ethnic minority–White American differences in psychological distress and psychopathology. The "minority status" argument contends that society, in part, stratifies people according to their ethnic or racial background. Institutionalized racism creates obstacles to economic, educational, and occupational parity in American society (Duncan, 1969; Farley, 1984; Allen and Farley, 1986). Economic differentials between minorities and White Americans represent a social "tax" on minorities for not being White (Willie, 1979). The discrepancies between minorities and dominant group members create a social environment characterized by alienation, frustration, and powerlessness. Distress, demoralization, and more serious forms of psychopathology are likely to result from this environment (Silberman, 1964; McCarthy and Yancey, 1971).

The "social class" argument holds that race differences in psychopathology disappear when social class is controlled. This argument is based on the fact that in many communities members of some ethnic minority groups have lower incomes than White Americans. Although members in the lower social classes exhibit higher levels of distress regardless of their ethnic minority status (Warheit et al., 1975; Ilfeld, 1978; Roberts et al., 1981; Roberts and Vernon, 1984; Neff, 1985), lower class members cannot access the economic and social resources to cope with the debilitating effects of their physical and social environment. Much of the current research seems to support a social class explanation (Ulbrich et al., 1989).

The minority status–social class debate has important consequences for the provision of prevention and treatment services. If minority status is a key correlate of psychopathology independent of social class, programs specifically targeting ethnic minorities appear justified. However, if social class is a more salient determinant of mental health problems, policymakers should emphasize more "universal programs" aimed at resolving economic barriers confronting individuals regardless of ethnicity. The debate over prevalence rate has continued, and it is worth noting that the thrust of the issue may be more complex than is currently conceived. For example, some researchers argue that the minority status and the social class perspectives are not mutually exclusive; and ethnic minority status is an important variable especially as it interacts with social class. Neighbors (1990) suggested that because of their limited access to power and resources some ethnic minority groups may be more at risk to

live in poverty, which in turn increases their chances of developing mental health problems.

### *Use of Mental Health Services*

It has been widely confirmed by a number of independent empirical studies that ethnic minorities do not actively seek professional care for their psychological or emotional problems as often as others do. When they use professional mental health services, treatment has tended to be inappropriate or inadequate to meet their needs. Ethnic minorities also tend to have differential diagnoses and often receive treatment that is severe and intrusive. The authors review some of the general findings related to these conclusions.

Most people who have had a mental disorder, regardless of race or ethnicity, do not use professional mental health services (Link and Dohrenwend, 1980); and ethnic minority group members are less likely to use mental health services than White Americans (Leaf et al., 1985). For example, the available evidence suggests that the utilization pattern of African Americans is distinctively different from that of White Americans. Using data from two national samples, Broman (1987) documented that although African Americans and White Americans are equally likely to seek some source of professional help for their emotional problems, White Americans are 1.6 times more likely than African Americans to contact a mental health resource. Sussman and colleagues (1987) confirmed these findings with data from the St. Louis Epidemiologic Catchment Area program. Among adults meeting DSM-III criteria for a major depressive episode, African Americans were less likely than White Americans to consult a mental health professional.

Minorities may resist using Western mental health services because they have a different conception of mental health problems than White Americans; they associate stigma with the receipt of mental health services; they have little faith in the benefit of psychotherapy; they fear institutionalization; or they have limited awareness or access to existing services (La Fromboise et al., 1980; Guilmet and Whited, 1987; Sussman et al., 1987; Snowden and Cheung, 1990). Minorities, who may be more comfortable speaking a language other than English, may resist using mental health programs that do not include a bilingual professional staff.

When ethnic minorities enter the mental health system, they seem to receive discriminatory care. Snowden and Cheung (1990) found that Asian Americans tended to remain in inpatient treatment for a longer time than White Americans. African Americans are more likely than White Americans to use emergency psychiatric services (Hu et al., 1991; Snowden & Holschuh, 1992). Rosenfield (1984) found that the African Americans who use emergency services are more often coercively referred to a hospital than a comparable group of White Americans.

Ethnic minorities may also receive differential clinical diagnoses than White Americans for the same problems upon entry into mental health clinics. The issue of diagnosis is important because it has implications for determining the

extent to which a consumer actually needs services. Moreover, because clinical diagnoses are influential in guiding proper treatment, a misdiagnosis can lead to improper care. There may be a tendency to label behaviors of some ethnic minority groups as deviant more often than for other groups. For example, evidence suggests that African Americans are overdiagnosed for schizophrenia and underdiagnosed for affective disorders (Adebimpe, 1981; Neighbors et al., 1989; Snowden and Cheung, 1990). Some scholars have wondered whether this pattern is due to actual differences in minority–White American distribution of psychiatric disorders or errors in clinical diagnoses (Neighbors et al., 1989). The issue can be summarized as one of "overpathology and underpathology." The provision of mental health services in ethnic minority communities can be biased in two, opposite directions (Lopez, 1989). On one hand, mental health problems can be "overpathologized" in some ethnic minority communities. Within this context, there may be a tendency to diagnose mental or emotional problems as the root cause of "problem behaviors" exhibited by minorities. This tendency may be in error, as the behavior may be a normal response to living in adverse conditions, such as poverty. Conversely, mental health problems can be "underpathologized" in ethnic minority communities as well. The empirical literature on ethnic minority mental health argues that problems may go unnoticed, especially in communities where minorities are labeled as "problem-free," as in the case of Asian Americans. Underpathologizing and overpathologizing can prove detrimental, and research is needed to understand the extent of these biases in various ethnic minority communities (Good, 1992–1993).

The notion that minorities may find the mental health system incompatible with their needs is partly found in the high dropout rate reported in the empirical literature. Sue and McKinney (1975), in a classic study, documented that at least 50 percent of the minorities compared to 30 percent of the White Americans dropped out of treatment. Dropout or premature termination was defined as the failure to return for treatment after one session. The definition of premature termination makes intuitive sense, as the first session represents the adult's initial contact with the mental health program. Failure to return after this session may reflect a dissatisfaction with services. This situation assumes, from the therapists' point of view, that more than one session was needed. One should recognize that a failure to return after the first session may reflect the client's (and family's) perception that the goals for treatment were met despite the mental health professional's sense that treatment should have continued. This explanation also suggests that mental health practitioners and minorities may not have the same ideas about the intent of mental health services. Although studies have documented that the difference in dropout rates between minorities and White Americans has diminished (O'Sullivan et al., 1989; Snowden et al., 1989), premature termination remains a useful barometer of the mental health system's effectiveness in working with minorities (Neighbors et al., 1992; Sue et al., 1993).

The pattern of inequities in service use among ethnic minorities is complex and may vary across local service systems and organizational factors. For ex-

ample, Hu and colleagues (1991) examined the service use of 4000 of the most severely disturbed and disabled consumers in two California counties. They investigated utilization of vocational and socialization programs, residential care, partial hospitalization, medication, assessment, and group and individual therapy. They also examined two forms of care that indicated failure of support of the client in the community: psychiatric emergency care and hospitalization. Multivariate models were estimated to provide statistical controls.

The data revealed considerable variation according to county. In one county, Asian American consumers were assigned a wide range of community-based programs and services (e.g., assessment, medication, partial hospitalization, and individual psychotherapy) more often than White Americans. Latino American consumers were more likely than their White American counterparts to receive medication and individual therapy. At the same time, both Asian American and Latino American consumers made less use of the emergency room and inpatient care than did White Americans. In an adjoining county, Asian American consumers were less likely than White Americans to be assigned to assessment, partial hospitalization, or residential care. Both groups were more likely than White Americans to be hospitalized. Utilization by African Americans was complex and varied. In the first county, African Americans were more likely than White Americans to be assigned to undergo assessment and receive medication and were less likely to be hospitalized. In the second county, African Americans were more likely than White Americans to use emergency services and to be hospitalized.

In summary, empirical evidence implicates community mental health services as insensitive to the needs of adults with a serious mental illness in ethnic minority communities. In addition, the psychotherapeutic process itself can be incompatible or problematic for ethnic minorities (see Sue et al., 1993). Accordingly, ethnic minority service providers and researchers have called for making the mental health system more "multicultural," that is, sensitive and responsive to the needs of ethnic minorities. The number and breadth of these recommendations have been extensive. However, few studies have identified the parameters of cultural sensitivity or assessed the factors that contribute to making the mental health system more effective for minority groups. For example, O'Sullivan and his colleagues (1989) found a significant decrease in the dropout rate from mental health clinics of ethnic minorities over a 10-year period and concluded that these changes were a result of culturally responsive services. However, no direct evidence was provided to establish that culturally responsive services actually led to improvement in these dropout rates. The next section reviews some attempts to address the issue of culturally responsive services in more detail.

### *Culturally Responsive Services*

Rogler and his colleagues (1989) argued that problems attributed to cultural insensitivity are partly due to the incongruence between the characteristics of the mental health system and the minority culture. That is, assessment instru-

ments, clinicians, and practices and policies in mental health programs and systems do not adequately address the needs of minority clients. It is this dissimilarity that leads to underutilization and poorer treatment outcomes among minorities. Along this same line, Sue (1977) made a number of recommendations to improve the delivery of mental health services to members of minority groups including: (1) making changes within existing services, such as hiring more ethnic specialists or training mental health care providers to work with minority groups; (2) establishing independent but parallel services specifically devoted to ethnic minorities; and (3) creating new, nonparallel services that are culturally relevant. Over the past two decades, many ethnic specialists have been trained, programs have been instituted by various associations and agencies to train clinicians and staff to work with minority consumers, and more programs targeted for ethnic minorities have been implemented. The last recommendation, the development of new, nonparallel services devoted for ethnic minorities, has not been implemented to any large extent. Despite the progress in two of these areas, the impact of these initiatives on improving the delivery of mental health services to ethnic minorities has been largely ignored.

During the past decade, many ethnic professionals have been hired by community psychiatric clinics. In some instances, staffing mental health clinics with more ethnic minority professionals has led to an increase in the utilization of services among ethnic minorities (Wu and Windle, 1980). However, the employment of ethnic minority professionals is related to the more complex issue of cultural similarity. The ability of a therapist (and other staff) to empathize with a consumer plays a critical part in shaping the interaction between the two parties and in defining deviant behavior (Blumer, 1969). When a therapist can take the role of the actor, the interaction is based on a shared understanding (empathy). Empathy is more likely to occur between people or groups of people who are socially or culturally similar (Rosenberg, 1984). Conversely, when a therapist and consumer are socially or culturally distant, there is less likelihood that the interaction will meet both parties' needs (Scheff, 1984). Matching consumers with therapists on the basis of ethnicity is seen as one method for operationalizing social and cultural similarity.

Although some researchers cite the importance of match, few empirical studies have been conducted, and the results of these investigations have been mixed (Jones, 1978; Jones and Matsumoto, 1982; Sue, 1988). Sue and his colleagues (1991) conducted one of the first studies of ethnic match and its effects on utilization and outcome in community mental health clinics. Their study showed that ethnic match has different consequences for the three ethnic minority groups included in the study. Among Asian Americans and Mexican Americans, ethnic match resulted in reducing premature termination, increasing the length of stay, and, among certain subgroups, improving treatment outcomes. For African Americans, ethnic match resulted primarily in increasing length of stay. Thus there is some initial evidence that the hiring of bilingual and ethnic staff can have important consequences above and beyond improving the representation of ethnic minorities in the community mental health system.

The data from the research of Sue et al. (1991) were not sufficiently robust to provide an understanding about the reasons for their results. In any event, matching simply on the basis of ethnicity may be an inadequate proxy for examining cultural similarity. Moreover, for some ethnic groups, such as American Indians and Alaska Natives, the number of ethnic therapists is relatively small to meet the potential demand for treatment. Future investigations must extend beyond the notion of ethnic match to examine the interaction, contextual factors, and cognitive processes that occur between ethnic therapists and consumers (Jones and Matsumoto, 1982; Good, 1992–1993). In the long term, these studies might better explore the issue of cultural similarity than ethnic match. Understanding the interplay of these factors would be useful for developing better training programs for ethnic and nonminority mental health professionals.

Sue (1988) also recommended the development of parallel mental health programs. Parallel models refer to programs that are similar to existing, more mainstream programs but that are devoted to ethnic minority groups. The most frequently cited aspect of appropriate services is the availability of bilingual and bicultural services. We have previously discussed the rationale for matching ethnic clients with a therapist from the same ethnic group. In parallel programs, staff purposely assume more case management functions because mental health difficulties may be intertwined with a number of other human service needs. Thus case managers are able to provide or refer clients for other types of nonpsychological services, such as social, financial, economic, legal, medical, and educational (Owan, 1982). Appropriate services may also include the effective use of existing natural support systems in the client's community, such as family and relatives, a pastor, an indigenous healer, or respected community leaders. Participation in this support network has been known to reduce the client's and family's resistance to psychological treatment and thus play a critical role in the duration and outcome of treatment (Child and Adolescent Service System Program, 1989).

The empirical literature evaluating parallel or ethnic programs is sparse, but the preliminary evidence suggests that parallel programs have been effective in increasing utilization among certain ethnic minority groups (Owan, 1982; Bestman, 1986; Bobo et al., 1988). In separate studies, researchers in northern and southern California have begun to show the effects of parallel programs for different ethnic minority groups. Using data from Santa Clara and San Francisco Counties, Snowden and colleagues (1993a,b) found that programs serving mostly ethnic minority consumers provided more outpatient services but fewer case management services than did programs that served primarily White American consumers. The ethnic minority programs were effective in reducing the reliance on emergency services. These effects were consistent for African Americans, Asian Americans, and Latino Americans. Snowden and his colleagues controlled for the effects of ethnic match and other sociodemographic and clinical variables. Takeuchi and colleagues (1993) found that ethnic minority programs reduced dropout rates and increased the utilization of outpatient services among African Americans, Asian Americans, and Mexican Americans. As with the studies of Snowden et al., Takeuchi et al.

(1993) controlled for the effects of ethnic match, sociodemography, and clinical variables.

Thus empirical findings are beginning to document the effect of ethnic minority programs on utilization patterns. These studies represent an emerging area of inquiry, but the reasons for the program effects are less clear. Ethnic minority programs may serve a different ethnic minority population than mainstream programs, or they may provide services that are socially and culturally compatible with the needs of the ethnic minority consumers. It is apparent that investigations are needed to understand the features that contribute to the differences found between interventions designed for ethnic minorities and other programs.

Beyond attempts to make mental health programs more responsive to the needs of ethnic minorities, some scholars and program planners have suggested alternatives to the current mental health system. Vega and Murphy (1990) argued that mental health systems are based on Western concepts of mental health, and new models must be initiated to focus on the pressing needs in minority communities. For example, because ethnic minorities may find Western mental health programs unacceptable, community mental health programs may need to redefine their services and reach out to a constituency broader than just the seriously mentally ill. Mental health programs can become more efficient and effective by addressing the environmental stressors that ethnic minority communities endure rather than simply focusing on people with serious mental illnesses (Lefley, 1979; Barrera, 1982). Although a number of impressive points are made on behalf of this argument that can be incorporated in a public health model (Neighbors et al., 1992), it seems unlikely that these alternatives will be systematically addressed in the near future. In fact, given the current condition of small budgets for mental health programs and a concerted direction toward managed care and standardized operations, ethnic minority mental health programs may be forced to take a narrow view rather than a broad conceptualization of mental health.

## Implications for Mental Health Services Delivery

It is perhaps appropriate to end this chapter with a comment on the financing and organization of publicly funded mental health services. Although seldom considered in discussions of multiculturalism, emerging public sector financing and reimbursement patterns may more profoundly affect the future of mental health services for ethnic minority populations than historic and current treatment philosophies and trends. It is especially so with respect to the movement toward capitation coupled with cost containment evidenced in many local mental health systems.

In general, as resources for disability services are diminished, public bureaucracies tend to employ clinical and medical criteria that limit service access (Stone, 1984). This statement precisely describes the current climate in the mental health field. The small gains made during the 1970s toward community

mental health and social welfare have rapidly deteriorated. As public support and financing erodes, the public sector is returning to a medicalized model of services and, more recently, to "managed mental health care." In the new managed care models, demonstration of "medical necessity" increasingly becomes the key criterion for determining access to services (Glazer, 1992), despite what Glazer (1992) noted as the lack of clear biological bases undergirding the concept of "medical necessity" in mental health. In the absence of strict medical criteria, service systems are forced to substitute what are clearly social and cultural criteria, such as a client's ability to function appropriately and adequately in the community (Glazer, 1992). Thus the criterion of medical necessity, and with it access to publicly funded services, hinge more on political than medical considerations.

In such a climate there may be a tendency to uniformly accept the constraints placed on services that attempt to be "multicultural." This point is particularly true for ethnic minority groups, which tend to be politically and often economically disadvantaged. To avoid repeating the failures of other reforms, the current climate can be viewed as an opportunity to rethink ways to make the mental health system more responsive to ethnic minority concerns. Since the 1970s ethnic minorities have made some gains in terms of entering key positions in academia, business, and politics. We must take advantage of these achievements to advocate that the mental health system values the role of culture and social factors in the delivery of services. Moreover, advocates must continue to clarify the purposes and scope of ethnic minority mental health services in contemporary society. Through a constant process of reconceptualization, advocacy, and monitoring, it may be possible to achieve a public health model of mental health services that is based on a full consideration of how social structure and culture affect mental health (Vega and Murphy, 1990; Neighbors et al., 1992).

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