Critical Disparities

Acknowledgments

This report was a collaborative effort of the NCLR/California State University, Long Beach (CSULB) Center for Latino Community Health, Evaluation, and Leadership Training and the National Council of La Raza (NCLR). Britt Rios-Ellis, Ph.D., Director of the NCLR/CSULB Center was the primary author.

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NCLR and CSULB would like to recognize and thank John Hixon, Executive Director, Brand Marketing, and Courtney Lang, U.S. Public Affairs Liaison, of Eli Lilly and Company for their vision and support for equality in mental health research, services, and treatment for Latinos. We would also like to extend our appreciation to Dr. John Oliver and Judy Green, M.S.W., of the Department of Social Work; Dean Ron Vogel and Renee Hannan of the College of Health and Human Services; Dr. Victor Rodriguez and Dr. Juan Benitez of the Department of Chicano Latino Studies, Dr. Robert Friis of the Health Science Department, Dr. Tony Sinay of the Health Care Administration Program, President Robert Maxson and Dr. Dixie Grimmett of the CSULB Office of the President; Jorge Daboub, Vice President of Marketing and Business Development and Teresa Quevedo, News Anchorwoman, of Univision; Sara Elena Loaiza and Ara Najarian, Managing Partners of Latino Health Consultants; and numerous faculty and students at CSULB for the many contributions they made to the success of the Latino Mental Health Summit, held at California State University, Long Beach in February 2005.

NCLR Vice President for Research and Strategic Initiatives Sonia M. Pérez and Jennifer Kadis, Director of Quality Control, provided overall technical support and copy editing to prepare the paper for dissemination. Rosemary Aguilar Francis, Director of the Graphics and Design Unit, was responsible for layout and design.

The preparation of this report was made possible by funding by Eli Lilly and Company. The final content of the report is the sole responsibility of the paper's author and NCLR. Permission to copy, disseminate, or otherwise use information from this paper is granted, as long as appropriate credit is given to NCLR.

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death for all Latinos (24%), followed by cancer (20%), unintentional injuries (8%), cerebrovascular disease (6%), and diabetes (5%). Furthermore, a recent Supplement to the Report of the Surgeon General on Mental Health (Department of Health and Human Services, 2001) found that Latinos with diagnosable mental disorders underutilize mental health care. In particular, Latinos have recently been identified as a high-risk group for depression, anxiety, and substance abuse (National Alliance for Hispanic Health, 2001).

Latino immigrants with mental disorders, fewer than one in 20 uses services from a mental health specialist, while less than one in ten uses services from a general health care provider (A Report of the Surgeon General, 2001). In a study using the Los Angeles-Epidemiologic Catchment Area Sample, Mexican Americans with mental disorders reported using both health and mental health services at a lower rate than non-Hispanic Whites (11.1% versus 21.7%, respectively) in the six months prior to the research interview (Hough, Landsverk & Karno, 1987). Similarly, in a study conducted in Fresno, California, only 8.8% of Mexican Americans with mental health disorders during the 12 months prior to being interviewed used mental health specialists (Vega, Kolody & Aguilar-Gaxiola, 1999). Furthermore, there is a great problem with recidivism in mental health care with more than 70% of Latinos who do access mental health services not returning after their first visit (Aguilar-Gaxiola, 2005). The underutilization of mental health services coupled with low rates of antidepressant medication use can be attributed to the prevalence of chronic depression among Latinos more than any other group (Aguilar-Gaxiola, 2005).

According to the National Alliance for the Mentally Ill (NAMI), there are two sets of issues that affect access to treatment for Latinos with mental illnesses:

- **Inadequate sources of treatment** - Primary care physicians are responsible for prescribing 67% of psychotropic agents and 80% of antidepressants, signifying that primary care providers are often diagnosing their patients' mental health problems (Chapa, 2004; Snowden, 2003). In particular, Latinos are twice as likely to seek treatment for mental disorders in non-mental health settings, such as the offices of general health care practitioners or faith-based organizations. These findings point to the dire need for an improvement in detection and care within the general health care sector. In addition, results from the Mexican American Prevalence and Services Survey (MAPSS) indicate that the most commonly reported barriers to receipt of mental health care services were lack of knowledge of where to seek treatment, lack of proximity to treatment centers, transportation problems, and lack of available Spanish-speaking providers who are culturally and linguistically trained to meet the needs of Latinos (Aguilar-Gaxiola, Zelezny, Garcia, Edmonson & Alejo-Garcia, 2002).
- **Insufficient Latino personnel** - There is a distressing lack of Latinos working as professional mental health providers. A national survey by Williams and Kohout (1999) revealed that out of 596 licensed psychologists with active clinical practices who are members of the American Psychological Association, only 1% of the randomly selected sample identified themselves as Latino. Furthermore, in 1999, the Center for Mental Health Services (CMHS) reported the existence of 20 Latino mental health professionals for every 100,000 Latinos in the United States. Latinos' reluctance to utilize mental health services may best be described by the *dicho* (saying) "*No se lava la ropa en casa ajena*" (One must not wash their dirty clothes in someone else's home). In other words, problems are handled within the family and should not be discussed or revealed outside of the home.

This information suggests that until Latinos are able to receive care by professionals who represent their population, understand their cultures, and speak their languages, mental health issues will continue to disproportionately affect the fastest-growing sector of the U.S. population, and the stigma surrounding mental health care will further deter Latinos from accessing services.

IV. IMMIGRATION AND ACCULTURATION

The majority of Latinos in the U.S. are native-born, but a significant share - about two in five - are immigrants. Although immigrants tend to fare better than their non-immigrant counterparts in terms of mental health issues, the stress experienced by individuals who have left their families and social support systems in their countries of origin has been well documented. A combination

of factors, including the acculturation process,* isolation due to lack of health insurance, little or no knowledge of the health care system, lack of Spanish-speaking providers, little or no English skills,** and low literacy, are important in understanding and addressing mental health concerns among Latinos.

Mental Health Differences between Immigrant and U.S.-Born Latinos

As outlined below, mental health issues affect both the native-born and immigrant segments of the U.S. Latino population, but depression and other conditions are manifested differently in each.

Research has shown that higher rates of mental illness are reported among U.S.-born and long-term residents than among recent Latino immigrants. When comparing U.S.-born Mexican Americans and Mexicans in Fresno, California, the National Co-Morbidity Study (NCS) and the Fresno Study found that U.S.-born Mexican Americans experienced almost double (48.1% vs. 24.9%) the lifetime prevalence of CIDI*** disorders than their U.S.-born counterparts (Vega,

more acculturated through the process of adaptation to, and survival within, the U.S. Studies point to few exceptions to the decline in mental health status that occurs among Latinos as they acculturate. The only subpopulation that has not shown dramatic increases in mental health issues when comparing immigrants and U.S.-born has been Cuban Americans in South Florida (Turner & Gil, 2002). This phenomenon could be the result of the strong socioeconomic and political base Cubans have developed in South Florida.

Family functionality may buffer the effects of acculturative stress. For Latinos, initial signs and symptoms of acculturative stress may include negative psychological consequences, such as emotional distress, shock, and anxiety. Berry (1990) noted that immigrants experienced various levels of acculturative stress and that elevated levels of this stress are likely to result in increased levels of depression and suicidal ideation (Hovey & Magaña, 2002). In addition, an imbalance between perceived demands and perceived resources upon immigration to the U.S. may prove to increase mental health instability. Research has demonstrated that a well-functioning and supportive family environment provides a buffer from acculturative stress, particularly in the initial periods of acculturation (Miranda & Matheny, 2000; Cortes, 1995; Miranda, Estrada & Firpo-Jimenez, 2000).

Consequences of Acculturative Stress

Latinos' experience of acculturative stress has frequently been associated with fatalistic thinking (Ross, Mirowsky & Cockerham, 1983). Many experience decreased self-efficacy, depression, and low social interest (Miranda, 1995). In addition, recent immigrants suffer acculturative stress related to changes in lifestyle, environment, and altered social support, which are associated with an increased risk of obesity, diabetes, and cardiovascular disease (Gonzalez, Haan & Hinton, 2001).

Acculturative stress, and stress experienced upon immigration to the U.S., has a pervasive, lifelong influence on Latinos' psychological adjustment, decision-making abilities, occupational functioning, and overall physical and mental health (Smart & Smart, 1995). Moreover, the majority of Latinos expressing acculturative stress, and stress related to immigration, are influenced by many other factors including language barriers, deficits in coping resources, lack of cohesion with family members, and the short tenure of U.S. residency (Miranda & Matheny, 2000). Although not all Latinos develop depression upon immigration to the U.S., it is likely that a certain degree of biological or psychological vulnerability, combined with social vulnerability after immigration, may lead to a sense of depression (Bhugra, 2003). Changes in cultural identity may subsequently lead Latinos to suffer from culture shock.

Furthermore, cultural distance may contribute to a sense of alienation and isolation, thereby leading to depression and acculturative stress (Bhugra, 2003). Cultural distance can become increasingly problematic when immigrant parents sense a loss of connection with their more acculturated children (Suro, 1999). This can be exacerbated further when subsequent generations are not able to communicate effectively with their relatives due to both linguistic and cultural barriers.

An additional concern related to the acculturation process is the extent to which immigrants are expected to gradually and completely relinquish their cultural mores and adopt those of the country of residence. When acculturation is interpreted as a unidimensional and unidirectional process, it more accurately resembles assimilation and can be accompanied by stress. By contrast, an increasing number of studies strongly indicate the positive mental health effects of biculturality as perhaps the ideal acculturative stage due to the fact that bicultural Latinos are less likely to be depressed and more likely to demonstrate high social interest (Miranda & Umhoefer, 1998; Berry, 1990; Lang, Muñoz, Bernal & Sorensen, 1982).

Other Concerns

Latino mental health is also influenced by additional stressors such as refugee or undocumented status, experiencing the threat of or having previous history with deportation, and isolation in the absence of family or social support (Ramos & Carlson, 2004). Given that a significant share of Latinos are immigrants, many Latino families and their children strive to assimilate and adopt to mainstream U.S. culture, and the influence of these processes on their mental and emotional health is marked. Many Latino immigrants perceive the process of immigration to the U.S. as a traumatic experience that negatively affects their self-esteem and overall sense of identity (Harker, 2001). Due to the fact that a large proportion of Latino children are immigrants themselves or have immigrant parents, their adaptation to the U.S. merits attention.

Although most research concerning recent immigrants has focused on adults, very little data are available to accurately describe young immigrant children and their adaptation to U.S. mainstream culture (Harker, 2001). Latino children frequently serve the role of cultural brokers for their families and are often left to translate when accessing the health care system. While health care agencies are required to provide translation for all individuals seeking care under Title VI of the Civil Rights Act of 1964, the reality is that translators are not always available in times of need, particularly within highly impacted organizations and emerging communities experiencing rapid demographic changes. Furthermore, Latino children are especially likely to live in poverty and lack health insurance and access (U.S. Bureau of the Census, 2004). Due to the lack of regular interface with health providers, many Latinos have little knowledge of their health care rights and what to expect in contemporary U.S. health care settings. Additionally, due to a range of well-documented academic barriers, a large share of Latino children and youth experience poor educational outcomes, resulting in decreased opportunities for employment and health care access, while contributing to high-risk behaviors that may contribute to poor mental health (Vega & Alegria, 2001).

V. CHEMICAL USE AND DEPENDENCY

One of the most harmful consequences of poor mental health occurs when individuals are prone to excessive alcohol and illicit drug use. Cultural dissonance and acculturative stress, discrimination, socioeconomic pressures, loss of social support mechanisms upon immigration, and exposure to drugs and alcohol often lead to chemical use and dependency. Indeed, substance abuse is the most common and clinically significant co-morbidity among people with mental health illnesses (Drake, Mueser, Brunette & McHugo, 2004).

Alcohol Use

Among Latinos, use of alcohol is of particular concern given that data have shown that:

- **Death rates linked to alcohol-related conditions like cirrhosis and chronic liver disease are exceptionally high among Latinos** (Caetano & Galvan, 2001). While the category of cirrhosis and chronic liver disease is not included in the top leading causes of death for African American, White, and Asian/Pacific Islander males or females, it is the seventh- and tenth-leading cause of death for Latino men and women, respectively (CDC, National Vital Statistics Reports, 2003, Vol. 52, 9).
- **Latino youth are more likely than both African American and White youth to have consumed alcohol prior to driving or have ridden with a driver who has consumed alcohol** (Caetano & Galvan, 2001). Moreover, the number of deaths related to alcohol consumption while driving, riding in a car with a driver who has consumed alcohol, and/or

alcohol-related homicide is higher among Latinos, compared to their African American and White counterparts (Crowley, 2003).

- **Latino youth are more likely than their counterparts to have consumed alcohol in their lifetimes and to report current use of alcohol**. Data from the Youth Risk Behavior Surveillance Report (1999) also show that Latino youth are more likely to report episodic heavy drinking when compared to their Anglo and African American counterparts (Caetano & Galvan, 2001). Moreover, several studies have identified predictors of drinking among Latino youth (Sokol-Katz & Ulbrich, 1992) and stipulate that males and older adolescents consume significantly more alcohol than females and younger adolescents. In addition, a higher level of alcohol consumption tends to be reported more frequently by Mexican adolescents living in single-parent homes than those in two-parent homes.

Subgroup data related to prevalence estimates suggest that alcohol use and dependency are higher among Mexican-origin men when compared to women (Vega, Scribney & Achara-Abrahams, 2003). Men of Mexican origin have been found to be disproportionately affected by alcohol-related diseases and alcohol-related deaths.

Decisions to use alcohol (and tobacco) are influenced by many factors, including education, whether parents drink/smoke, peer pressure, and acculturation. For example, as Hispanic women acculturate to U.S. norms and values, they are more likely to consume alcohol (Wolf & Portis, 1996). Recent research from the National Latino Council on Alcohol and Tobacco Prevention also shows that alcohol and tobacco company advertisements or support of community events seek to - and do - influence Latinos' patterns of consumption of these products.

Substance Use

Data from the Hispanic Health and Nutrition Examination Survey (HHANES), a national probability sample of Hispanics aged 12 to 74, suggest differing patterns of substance use among segments of the Latino population. For example:

- Mexican Americans and Puerto Ricans were more likely to be past or present drug users than were Cuban Americans. More than two in five Mexican Americans (42%) and Puerto Ricans (43%), compared to one in five (20%) Cuban Americans, reported having used marijuana at some time in their lives (USDHHS, SAMHSA, 2003). Moreover, analyses of HHANES demonstrated that acculturation into mainstream U.S. society may contribute to chemical use and dependency.
- Hispanics who preferred to be interviewed in English were two to three times as likely to have ever used drugs when compared to their Latino counterparts who preferred to be interviewed in Spanish.
- Among Hispanics who reported ever having used marijuana, Mexican Americans initiated use at earlier ages than Puerto Ricans.

Although marijuana and illicit drug use have been historically lower for Latinos when compared to African Americans and Whites, small increases in marijuana use among Latinos overall have

migrant construction workers, food service workers, and agriculture workers (DHHS, 2000). According to the Drug and Alcohol Services Information System (DASIS, 2004) the proportion of primary methamphetamine admissions involving those who identified themselves as Latinos (especially Mexican) doubled in a recent ten-year period, from 6% in 1992 to 12% in 2002. Findings show that participants believed that methamphetamine use was on the rise among Mexican American workers in all occupations (DHHS, 2000). Study participants habitually reported that their first use occurred in an occupational setting. Often referred to as the "poor man's cocaine," most respondents stated that they had easy access to the drug and that price was not a barrier for them. Interviewees also reported that dealers regularly travel to work sites, including agricultural fields.

Overall, methamphetamine use has enabled many to work longer hours faster and, therefore, make more money. Dramatic increases in the use of methamphetamines have been found among Latinos in and around the U.S.-Mexico border. According to Lopez-Zetina (2004), among Latino users in San Diego and Tijuana, the most widely used drug is methamphetamine. In San Diego, most users are likely to have had the habit for seven years or longer and initiated use at or around the age of 17. Approximately two-thirds (65%) of San Diego Latino methamphetamine users report daily consumption. In Tijuana, where 28% of users consume daily, most are likely to have used for 12 years or longer and initiated use at the approximate age of 14. Due to the relative ease with which methamphetamine is produced, restrictions have increasingly been placed on the sale of pseudoephedrine and other components used in its manufacture, which are often found in popular cold and allergy remedies. These restrictions, however, have not yet been implemented in Mexico, resulting in the creation of methamphetamine manufacturers along the U.S.-Mexico border.

In addition to the health risks that stem from substance use and abuse, there are other consequences of concern for Latinos, especially related to education and the criminal justice system. There is a positive association between the initiation of drug use and school drop out, and further studies are needed to better understand this link for specific Latino subgroups (Chavez, Oetting & Swaim, 1994). As a group, Latinos in federal prison were the most likely to be convicted of a drug offense; in 2000, Latinos constituted 43.4% of all federal drug offenders (NCLR, 2002). According to estimates by the U.S. Department of Justice (1997), the lifetime probability of being incarcerated in a state or federal prison is four times higher for Latino males than White males.

VI. DOMESTIC VIOLENCE

Domestic violence is a serious, widespread social problem with mental health consequences for victimized women and families of all cultural and ethnic groups. Medical providers, clinicians, and policy-makers have become aware of the widespread prevalence of domestic violence, as evidenced by the increasing number of screening programs in emergency departments, as well as in primary care, obstetric, and pediatric facilities throughout the U.S., and in the passage of the Violence Against Women Act in 1994 (Dienemann, Boyle, Baker, Resnick, Wiederhorn & Campbell, 2000). Although certainly not the only contributing factor, alcohol and illicit drug use often are associated with domestic violence, and this link is also relevant for the Latino community.

Victims of domestic violence, who are overwhelmingly women, are at high risk for mental health problems (Carlson & McNutt, 1998). According to the American Medical Association (2001), battered and victimized women account for 22% to 35% of all women seeking emergency medical services, 25% of women who attempt suicide, and 23% of pregnant women who seek prenatal care (Torres & Han, 2003). Although much work has been attributed to recognizing the impact that

domestic violence has on women overall, few reliable data are available to describe the reality of Latinas who experience domestic violence. A recent study involving 1,088 low-income Latinas residing in Chicago, Boston, and San Antonio found that one-fourth of the participants had experienced domestic violence. Unmarried women with a history of violence in their families of origin and sexual abuse survivors (adult or child) who were born in the U.S. and speak English are especially likely to experience violence in their relationships (Frias & Angel, 2005).

Available information shows that, similar to their non-Hispanic counterparts, Latina women are more likely than men to be the victims of domestic violence, but Latina women have also been found to abuse their male partners. Data from the National Couples Study indicate that Latinos are more likely to have engaged in male-to-female partner violence than Whites and that more than 25% of Latinos and Whites reported having engaged in drinking prior to the violent episode. Latino males were also more likely than Whites to have experienced female-to-male partner violence, and between 25% and 33% of men reported having drunk alcohol when their partners became violent (Caetano & Galvan, 2001). Latinas were much less likely than their White female counterparts to have consumed alcohol at the time they became violent.

and respected. Research comparing women from rural Mexico whose husbands had traveled to the U.S. for work with those whose had not, found that women with husbands who did not live regularly in Mexico experienced increased levels of depression, aggression toward their male partners, and relationship dissonance when their husbands visited Mexico (Flores, 2005). This study showed that intimate partner violence (IPV) existed on both sides of the border and that it was defined differently among Latinos and Whites. For example, among Latinas accusation of being a "bad mother or wife" was viewed as one of the most severe abuses. Among Latino males, the most severe form of abuse was to be called "useless." Both of these items were not included on the scales that measured experience of violence, indicating a need to develop culturally-appropriate scales for IPV among Latinos. Both women and men were found to use verbal insults

likely to be compounded by lower income and educational status as well as unemployment. Furthermore, Latinas whose husbands are working in the U.S. are particularly prone to report higher levels of depression.

For these reasons it is essential that a thorough investigation be conducted regarding the ways in which violence becomes part of the daily lives and interactions within Latino families among both immigrants and non-immigrants. In addition, the identification of effective strategies, such as conflict resolution in marriage, is fundamental to effectively prevent IPV (Flores, 2005).

VII. SUICIDE

Each year in the U.S. approximately 30,000 people die by suicide and approximately 650,000 people receive emergency treatment after attempting suicide (CDC, 2004). More than 80 million people in the United States are at risk for suicide due to mental illness and substance-use disorders. Suicide is now the eleventh-leading cause of death for all ages and the third-leading cause of death for adolescents (Cabassa, 2005; CDC, National Vital Statistics Reports, 2003, Vol. 52, 9).

A combination of research and data offers some insight into the scope of the problem among Latinos. When compared to other groups, Kann et al. (1998) found that Latinos were more likely to have attempted suicide (10.7%) when compared to their African American (7.3%) and non-Hispanic White (6.3%) counterparts. Latinos were also found to be more likely to consider suicide (23.1%, vs. 15.4% and 19.5%) and make a specific plan (19.6%, vs. 12.5% and 14.3%) when compared to African Americans and non-Latino Whites, respectively. Data from the Centers for Disease Control show that suicide was found to be the seventh-leading cause of potential life years lost before age 75 years and the third-leading cause of death among young Latinos 10-24 years old (CDC, MMWR, 2004). Moreover, approximately 50% of all suicides occurred among Latinos 10-34 years old.

Latino youth appear to be at a significantly increased risk of suicide and suicide ideation when compared to Latinos overall. According to the CDC, Latino youth experience disproportionately high rates of anxiety-related and delinquent behaviors, depression, and drug use when compared to non-Latino White youth (CDC, 2004). Additional data on Latinos by gender and subgroup demonstrate:

- **Females:** When comparing Latinos, African Americans, and Whites, Hispanic adolescent females had much higher rates of suicide ideation and attempted suicide, and were more likely to require medical attention due to the attempt. Approximately one-third of Latina girls seriously contemplate suicide (SAMHSA, 2001). The National Household Survey on Drug Abuse indicates that Latinas aged 12 to 17 were at higher risk for suicide than other youth, with Latinas born in the U.S. at the highest risk (2000).
- **Males:** Among a total of 8,744 Latinos who died from suicide from 1997 to 2001, 7,439 were males (MMWR, 2004). An additional study of a more limited timeframe found that from 1999 to 2001, a total of 5,332 Latinos died from suicide, 85% of whom were males.
- **Subgroups:** Persons of Mexican origin accounted for the majority of suicides (56%), followed by those of other/unknown Hispanic origin (14%), Central and South Americans (11%), Puerto Ricans (11%), and Cubans (8%).
- **Methods:** The suicide method most frequently used by males was firearms (45%), followed by suffocation (34%) and poisoning (7%). In contrast, Latina females were likely to use firearms (29%), suffocation (29%), and poisoning (27%) almost equally. Among Latino male youth aged

10-24 years, firearms accounted for 52% of all suicides, followed by suffocation (38%) and poisoning (3%); whereas among females in the same age group, suffocation accounted for 44% of all suicides, followed by firearms (33%) and poisoning (11%) (CDC, 2004).

Suicide also affects other segments of the Latino population. For example, among Latinas, suicide rates were highest among those aged 50-54 years, followed by those 45-49 years old. In addition, Latino elderly have been found to be at increased risk, often the result of perceived inutility, lack of social support, or reaction to exacerbation of a chronic illness, such as recovery from an amputation resulting from diabetes.

Factors Associated with Suicide

Risk factors for suicidal behaviors among Latino youth (male and female) are complex and multifaceted. Some of the major factors are highlighted below:

- **Depresssion**. Major depression has consistently been the most prevalent condition leading to suicide ideation and contemplation among Latino youth.
- **Gender**. Youth suicide is marked by a distinct gender difference; although females are more likely than males to attempt suicide, males are more likely to commit suicide (Otsuki, 2002). Latinas are more likely to be hospitalized for self-inflicted injuries. According to Zayas et al. (2000), to deepen our understanding of the phenomena of adolescent Hispanic female suicide attempts and to better inform clinical practice, new culturally-based models need to be developed and tested.
- **Drugs**. Substance abuse is also a significant risk factor, especially for older adolescent males (Gould & Kramer, 2001).
- **Mental distress**.

VIII. CO-MORBIDITY AND MENTAL HEALTH

When mental illness is coupled with other leading causes of death among Latino men and

- **Funding for services for Latinos who lack health insurance or are unable to pay for diagnosis and treatment** is particularly important for undocumented Latinos, given that a large share of Latino families consist of members who are both documented and undocumented.

Enhancing domestic violence services for Latinos. This includes efforts to ensure that national and state hotlines or other services are linguistically and culturally competent. Consistent with this, Spanish-speaking staff at clinics, shelters, and other service areas should be available. In addition, shelters should allow the incorporation of children and use a family-centered approach to be responsive to Latinas.

Expanding substance abuse treatment services. Latino-centered alcohol and drug treatment centers where parents are allowed to bring their children are needed. Chemical use and dependency treatment facilities and programs should combine successful community-based organization interventions in the U.S. with proven components from Latin America to ensure culturally-relevant solutions without having to recreate entire service programs. Family-based treatment models that can be transcreated to meet the needs of Latino populations should be encouraged through developmental grant efforts. Additional policies can be written which, in turn, provide funding for replication of successful treatment models throughout the U.S.

Mandating policy to ensure adequate representation of Latinos and other racial/ethnic minorities in national studies and drug trials. Policies should stipulate that a representative number of minorities be included in mental health-related pharmacologic testing. Latinos, African Americans, Asian/Pacific Islanders, and Native Americans are woefully absent in clinical trial registries. When race and ethnicity are considered, African Americans have been found to be included at times, but never in sufficient quantities to yield meaningful statistical analyses (Vedantam, 2005). The combination of lack of representation of Latinos in clinical trials and the genetic diversity of Latinos overall has led to inappropriate psychopharmacology, due to variations in drug metabolism (Comas-Diaz, 1996; Mendoza & Smith, 2000).

Identifying Latinos and collecting data for Latinos and specific subgroups in pharmacologic trials. The tendency to include Latinos within larger categories, such as “minorities,” “non-whites,” or “women” in phar

Routinely screen diabetic, cardiovascular disease, and infectious disease patients for mental health problems, recognizing that a patient with compromised mental health status is less likely to adhere to a medical treatment regimen. Furthermore, poor mental health has been found to have deleterious effects on overall immune function and exacerbate disease progression.

Have the opportunity to engage in Latino-specific mental health training to remain abreast of research and programmatic strategies. This training must include linguistic components to

Second, **considering that so few Latinos currently occupy provider positions, it is critical that a community link is developed to ensure that individuals with mental health needs are**

adequate translation services become even more imperative. It is essential that patients are not made to rely on family members or their children for translation. Culturally- and linguistically-appropriate care must be ensured in all health care settings, particularly mental health, wherein the patient's description of his/her condition is often the only diagnostic criterion the provider has for making decisions regarding treatment regimens.

Incorporation of family in treatment. A great deal of current research is also pointing to the effectiveness of treatment modalities that incorporate the family and community. These are proving to be less costly when measured in both human and economic terms, with patients integrated in daily life and cared for within their homes as opposed to institutions. The WHO World Mental Health Survey Consortium has proven over three decades of research that schizophrenics treated in poorer countries with greater levels of social integration fair far better than they do when treated in industrialized nations, where they are more likely to be institutionalized, homeless, or incarcerated. Relatives tend to be more effective than hospital staff in calming troubled patients and play an active role in patient adherence to treatment regimens (Vedantam, 2005). Mental health institutions' accessibility to immediate and extended family members may improve treatment outcomes for long-term residents. *Familismo*, a term that describes the tendency to extend relationships beyond the nuclear family, should be incorporated into Latino-centered mental health treatment as it helps facilitate emotional proximity, affective resonance, interpersonal involvement, and cohesiveness (Falicov, 1992; Comas-Diaz, in press). The development of these factors can greatly improve both personal adherence to treatment as well as social support networks that lead to positive mental health outcomes. According to Jacobsen and Comas-Diaz (1999) cognitive behavioral therapy, family therapy, and group therapy techniques represent culturally-congruent approaches due to extended family ties and the strong importance placed on connectedness with Latino cultures.

Inclusion of other forms of treatment. Two additional treatment modalities, Eye Movement Desensitization and Reprocessing (EMDR) and Interpersonal Psychotherapy (IPT), have been pr

REFERENCES

Caetano, R. & Galvan, F.H. (2001). Alcohol use and alcohol-related problems among Latinos in the United Status. In: M. Aguirre-Molina, C.W. Molina & R.E. Zambrana, (Eds.), Health Issues in the Latino Community. San Francisco: Jossey-Bass, pp: 383-412.

Campbell, J.C. (2002). Health consequences of intimate partner violence. The Lancet, 359, pp: 1331-1336.

Canto, M.T. & Chu, K.C. (2000). Annual Cancer Incidence Rates for Hispanics in the United States: Surveillance, Epidemiology and End Results, 1992-1996. Cancer, 88: 2642-2652.

Carlson, B.E. & McNutt, L-A. (1998). Intimate partner violence: Intervention in primary health settings. Battered women and their families: Intervention strategies and treatment programs (2nd ed., pp: 230-270). New York: Springer.

Carlson, B.E., McNutt, L-A. & Choi, D.Y. (2003). Childhood and adult abuse among women in primary health care: Effects on mental health. Journal of Interpersonal Violence, 18(8), pp: 924-941.

Centers for Disease Control and Prevention/National Center for Health Statistics. (2002). Deaths, percent of deaths, and death rates for the 15 leading causes of death in 5-year age groups, by Hispanic origin, race for non-Hispanic population and sex: United States 2000. pp: 1-100 Retrieved November 8, 2004, <http://www.cdc.gov/nchs/data/dvs/LCWK4_2000.pdf>.

Centers for Disease Control and Prevention/National Center for Chronic Disease Prevention and Health Promotion. (2004). National Youth Risk Behavior Survey (YRBS). Health, United States. Morbidity and Mortality Weekly Report, 53, SS/2.

Centers for Disease Control and Prevention. (2004). Health disparities experienced by Hispanics - United States. Morbidity and Mortality Weekly Report, 53(40): 935-937.

Centers for Disease Control and Prevention. (2004). Suicide among Hispanics - United States, 1997-2001. Morbidity and Mortality Weekly Report, 53(22): 478-481.

Centers for Disease Control and Prevention. (2003). Deaths: Leading causes for 2001. National Vital Statistics Reports, 52(9), pp. 1-86.

Centers for Disease Control and Prevention. (2003). HIV/AIDS Surveillance Report, 15, Atlanta: U.S. Department of Health and Human Services, pp: 1-46. Retrieved November 8, 2004, <http://www.cdc.gov/hiv/stats/hasrlink.htm>.

Centers for Disease Control and Prevention. (June 11, 2004). Suicide Among Hispanics - United States, 1997-2001. Morbidity and Mortality Weekly Report. 53(22); pp: 478-481. Retrieved November 8, 2004, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm 5322a5.htm>.

Centers for Disease Control and Prevention. (June 11, 2004). Methods of Suicide Among Persons Aged 10-19 Years - United States, 1992-2001. Morbidity and Mortality Weekly Report. 53(22); pp: 471-474, Retrieved November 8, 2004, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5322a2.htm>.

Chapa, T. (2004). Mental Health Services in Primary Care Settings for Racial and Ethnic Minority Populations. Draft Issue Brief, September. Office of Minority Health.

Chavez, E.L., Oetting, E.R. & Swaim, R.C. (1994). Dropouts and Delinquency: Mexican American and Caucasian Non-Hispanic Youth. Journal of Child Psychology, 23(1), pp: 47-55.

Comas-Diaz, L. (in press). Ethnopolitical psychology. In E. Aldarondo (Ed.), Promoting social justice in mental health practice. New Jersey; Lawrence Earlbaum Associates.

Comas-Diaz, L. (2005). The mental health needs of Latinas. Presentation made at the National Council of La Raza Annual Conference. Philadelphia, July.

Comas-Díaz, L. (1996). Cultural considerations in diagnosis. In F. Kaslow (Ed.). Handbook of relational diagnosis and dysfunctional family patterns. New York: Wiley.

Copeland, L.A., Zeber, J.E., Valenstein, M. & Blow, F.C. (2004). Racial disparities in the use of atypical antipsychotic medications among veterans. The American Journal of Psychiatry, 160: 1817-1822.

Crowley, M.O. (2003). Latino access to mental health, development disabilities, and substance abuse services in North Carolina. North Carolina Medical Journal, 64(3): 127-128.

Department of Health and Human Services (2000). Communication Strategy Guide: A Look at Methamphetamine Use among Three Populations. Substance Abuse and Mental Health Services Administration Center Substance Abuse Prevention. DHHS (SMA) 00-3423.

Dienemann, J., Boyle, E., Baker, D., Resnick, W., Wiederhorn, N. & Campbell, J. (2000). Intimate partner abuse among women diagnosed with depression. Issues in Mental Health Nursing, 21, pp: 499-513.

Drake, R.E., Mueser, K., Brunette, M.F. & McHugo, G.J. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. Psychiatric Rehabilitation Journal, 27(4), pp: 360-374.

Drug and Alcohol Services Information System: The DASIS Report (2004). Primary Methamphetamine/Amphetamine Treatment Admissions: 1992-2002. Substance Abuse and Mental Health Services Administration. Retrieved November 8, 2004, <www.samshsa.gov/2k4/meth>.

Falicov, C. J. (1998). Latino families in therapy: A guide to multicultural practice. New York, Guilford Press.

Ferketich, M.A., Schwartzbaum, J.A., Frid, D.J. & Moeschberger, M.L. (2000). Depression as an antecedent to heart disease among women and men in the NHANES I study. Archives of Internal Medicine, 160, 1261-1268.

Ferraro, K. & Johnson, J.M. (1983). How women experience battering: The process of victimization. Social Problems, 30(3), pp: 325-329.

Fix, M.E. & Passel, J.S. (2001). Immigration at the beginning of the 21st century. Washington, DC. The Urban Institute. Retrieved November 8, 2004, <http://www.urban.org/url.cfm?ID=900417>.

Flores, Y. (February 16, 2005). Violence and depression among Latinas: Implications for mental health. Presentation conducted at The Latino Mental Health Summit, Long Beach, California.

Frias, S.M. & Angel, R.J. (2005). The risk of partner violence among low-income Hispanic subgroups. Journal of Marriage and Family, 67: 552-564.

Gil, A.G. & Vega, W.A. (2001). Latino drug use: scope, risk factors and reduction strategies. In M. Aguirre-Molina, C.W. Molina & R.E. Zambrana, (Eds.), Health issues in the Latino community. San Francisco, CA: Jossey-Bass, pp. 435-458.

Gonzalez, H.M. (2005). Mental health and medical co-morbidities: The case of older Mexican Americans. Presentation conducted at The Latino Mental Health Summit, Long Beach, California.

Gonzalez, H.M., Haan, M.N. & Hinton, L. (2001). Acculturation and the prevalence of depression in older Mexican Americans: Baseline results on the Sacramento area Latino Study on Aging. Journal of the American Geriatrics Society, 49(7), pp: 948-953.

Gould, M.S. & Kramer, R.A. (2001). Youth suicide prevention. Suicide Life Threat Behaviors, 31(1), pp: S6-S31.

Grant, B.F., Stinson, F.S., Hasin, D.S., Dawson, D.A., Chou, S.P. & Anderson, K. (2004). Immigration and lifetime prevalence of DSM-IV psychiatric disorders among Mexican Americans and Non-Hispanic Whites in the United States. Archives of General Psychiatry, 61:1226-1233.

Harker, K. (2001). Immigrant generation, assimilation, and adolescent psychological well-being. Social Forces, 79, pp: 969-1004.

Lopez, S.R. (2002). A Research Agenda to Improve the Accessibility and Quality of Mental Health Care for Latinos. *Psychiatric Services*, 53(12), pp: 1569-1573.

Lopez, S.R. (February 16, 2005). Acculturation and Mental Health. Presentation conducted at The Latino Mental Health Summit, Long Beach, California.

Lopez-Zetina, J. (2004). Uso de metanfetaminas en la frontera Mexico/Estados Unidos. Presentación el 10 de diciembre, 2004, Universidad de Baja California, México.

Matano, R.A., Wanat, S.F., Westrup, D., Koopman, C. & Whitsell, A.D. (2002). Prevalence of alcohol

National Institute on Drug Abuse. (2002). Info Facts. National Institutes of Health, U.S. Department of Health and Human Services. Retrieved on November 8, 2004, <http://www.nida.NIH.gov/>.

Otsuki, M. (2002). Southern California Center of Excellence on Youth Violence Prevention, University of California, Riverside. Fact Sheet: Youth Suicide. pp.1-10. Retrieved on November 8, 2004, <http://www.stopyouthviolence.ucredu/publications/factsheets/youthsuicide.pdf>.

Ramos, B.M. & Carlson, B.E. (2004). Lifetime abuse and mental health distress among English-speaking Latinas. Affilia, 19(3), pp: 239-256.

Rios-Ellis, B., Leon, R.A., Trujillo, E.F., Enguidanos, S., Dwyer, M., Ugarte, C. & Roman, R. (2003). From Words to Action: The evolution of a national Latina HIV/AIDS needs assessment. Ciencias de la Conducta, 18(1), pp: 78-104.

Rodriguez, M.A., Bauer, H.M., Flores-Ortiz, Y. & Szkupinski-Quiroga, S. (1998). Factors affecting patient-physician communication for abused Latina and Asian immigrant women. Journal of Family Practice, 47(4). Gale Group Inc. Retrieved February 10, 2005, <http://0-global.factiva.com.coast.library.csulb.edu/en/arch/print_results.asp>.

Soto, J.J. (2000). Mental Health Services Issues for Hispanics/Latinos in Rural America. In Motion Magazine: May 30.

Stonefeinstein, B.E.S. & Ward, C. (1990). Loneliness and psychological adjustment of sojourners: New perspectives on culture shock. In D.M. Keats, D. Munro & L. Mann, (Eds.), Heterogeneity in cross-cultural psychology: pp: 537-547. Lisse, Netherlands: Swets & Zeitlinger.

Suro, Roberto (1999). Strangers Among Us: Latino Lives in a Changing America. New York: Vintage Books.

Swanson, J.W., Linskey, A.O., Quintero-Salinas, R., Pumariega, A.J. & Holzer, III, C.E. (1992). A binational school survey of depressive symptoms, drug use, and suicidal ideation. Journal of the American Academy of Child and Adolescent Psychiatry, 669-678. 31.

The Commonwealth Fund. (2003). Insurance, access, and quality of care among Hispanic populations: 2003 Chartpack.

The National Institute on Drug Abuse (NIDA). (2002). Retrieved on November 8, 2004, <http://www.drugabuse.gov>.

Torres, S. & Han, H.-R. (2003). Women's perceptions of their male batterer's characteristics and level of violence. Issues in Mental Health Nursing, 24, pp: 667-679.

Turner, R.J. & Gil, A.G. (2002). Psychiatric and substance use disorders in South Florida: Racial/ethnic and gender contrasts in a young adult cohort. Archives of General Psychiatry, 59, 43-50.

U.S. Bureau of the Census. (August 2004). Income, poverty, and health insurance coverage in the