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"Bringing people together to serve humanity"

Highlighting the State of Mental Health for African American and Latino Communities: Insights, Intersectionality, and Initiative of What We Know and Need to Be Able to Do

Disparate access to mental health services for African American and Latino communities requires intentional efforts to address holistically the well-being needs for these traditionally underserved groups. While decades of research document these disparities, researchers share varying views on the degree to which various variables influence these inequities (Snowden, 2001; Whaley, 2001; Dana, 2002; Mama, Li, Basen-Engquist, Lee, Thompson, Wetter, & McNeill, 2016; Reynolds & Gonzales-Backen, 2017; Holden & Xanthos 2009). Nonetheless, religion is identified as a conduit for being able to cope with challenges associated with mental health, particularly as it relates to cultural background (Hechanova and Waelde, 2017; Lukachko, Myer, Hankerson, 2015). Researchers call for actively involving clergy and the church in the delivery of health services to offset the effects of racial discrimination and increase access to professional mental health services (Lukachko & Hankerson. 2015; Ellison, DeAngelis, & Güven, 2017). The manner in which religious communities are considered as a viable constituency to address structural and societal issues unique to mental health for African American and Latino communities is important toward minimizing the overall and devastating impact for these traditionally underserved groups.

Lukacho, Myer, and Hankerson (2015) particularly address the clashes that exist within cultures related to mental health as they indicate that "professional mental health care may clash with sociocultural religious norms" (p. 578). Hechanova and Waelde (2017) identify five areas for which mental health professionals need to be concerned: 1) emotional expression; 2) shame; 3) power distance; 4) collectivism; and 5) spirituality and religion. The focus on spirituality and religion particularly highlights how individuals access spirituality and religion in such a manner that is transferable into coping skills of mental health and the challenges therein (i.e. depression, anxiety). More specifically, within the Nashville Stress and Health Study (2017), as it relates to the Black Church, assert the following:

> Church-based social support may be particularly important for African Americans. On average, they tend to exchange instrumental and socioemotional aid informally with fellow church members more often than Whites from comparable backgrounds (Krause 2002, 2008). Several studies report that such congregational support, particularly socioemotional assistance, is linked with health and well-being among African Americans (Chatters et al. 2011, 2015; Ellison, Musick, and Henderson 2008; Head and Thompson 2017; Hope et al. 2017), perhaps more so than among Whites (Krause 2003, 2008a). Among African Americans, church-based support often augments and complements – rather than replicates the support that is available from family members and other non-kin ties (Nguyen, Chatters, and Taylor 2016).

The aforementioned perspectives indicate the intricate role of the church within the mental health affairs. African Americans tend to gravitate toward the church as a source of inspiration and comfort to respond to the varying pressures. More specifically, with Latinos, Caplan (2019) reports the following:

> Among the Hispanic/Latino faith-based communities in this study, mental illness and depression were culturally defined and often perceived to be a spiritual problem rather than a "sickness." This non-biomedical interpretation of illness is consistent with the findings of Breslau et al. (2017), indicating that Hispanics/Latinos (particularly Spanish-speaking individuals) have very low perceived need for mental health services irrespective of severity of illness. The importance of religion and religious coping as a means of treating of depression, as well as *Familismo*, or the necessity of family and community support, illustrate the cultural and religious values of many Latinos in the United States (Dalencour et al., 2017; Moreno, & Cardemil, 2013).

Findings from Caplan (2019) show how Latinos rely upon churches as a critical reliance of support for social, educational, and spiritual resources. Cultural values among Latinos are identified as a source of strength, but also serves as a contributor as a stigma. Within the faith-based community for Latinos, there is need for mental health literacy and anti-stigma interventions. Understanding what we know broadly from what broader and specific trends on mental health becomes critically important for contextualizing the role of the religious community to respond in intentional and relevant ways.

WHAT WE KNOW: INSIGHTS AND INTERSESCTIONALITY

Issues surrounding mental health are often plagued by misinformation and incomplete information which impact the perception of those who need these services as well as the likelihood of those persons to pursue the services they need. As extracted directly, following below is a table which identifies five commonly held fictitious views and clarifying facts regarding mental health (MentalHealth.Gov, 2022):

Table 1: Fact and Fiction Perspectives on Mental Health

FACT	FICTION
One in five American adults experienced a mental health issue One in 6 young people experienced a major depressive episode One in 20 Americans lived with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression	Mental Health problems don't affect me.
Even very young children may show early warning signs of mental health concerns. These mental health problems are often clinically diagnosable, and can be a product of the interaction of biological, psychological, and social factors. Half of all mental health disorders show first signs before a person turns 14 years old, and three-quarters of mental health disorders begin before age 24. Unfortunately, only half of children and adolescents with diagnosable mental health problems receive the treatment they need. Early mental health support can help a child before problems interfere with other developmental needs.	Children don't experience mental health problems.
The vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3%–5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population. You probably know someone with a mental health problem and don't even realize it, because many people with mental health	People with mental health problems are violent and unpredictable.

problems are highly active and productive members of our communities.	
People with mental health problems are just as productive as other employees. Employers who hire people with mental health problems report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees. When employees with mental health problems receive effective treatment, it can result in: • Lower total medical costs • Increased productivity • Lower absenteeism • Decreased disability costs	People with mental health needs, even those who are managing their mental illness, cannot tolerate the stress of holding down a job.
Mental health problems have nothing to do with being lazy or weak and many people need help to get better. Many factors contribute to mental health problems, including: • Biological factors, such as genes, physical illness, injury, or brain chemistry • Life experiences, such as trauma or a history of abuse • Family history of mental health problems People with mental health problems can get better and many recover completely.	Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough.

MentalHealth.Gov (2022) clearly articulates the plethora of perspectives for which those who need mental health and the internal and external challenges they encounter. Internally, individuals are faced with their own understanding, real or imagined, of what might be occurring with their mental health state. Externally, individuals are faced with a society and subsequent conditions that maintains or demonstrates an understanding, real or imagined, of who and/or what constitutes as a state of mental healthiness. MentalHealth.Gov (2022) also shows how mental health is a multi-layered phenomenon that cannot be solved with a one-size fits all

approach. Individualized and personalized, yet intentional, perspectives need to be considered when generating a solution. MentalHealth.Gov (2022) further highlights the need to be deliberate in how children are responded to and how adults are responded to involving mental health. Both require

One of the more comprehensive reports, *The State of Mental Health in America* (2022), as published by Mental Health America (MHA), highlights the diversified measures used to understand mental health in holistic ways:

1) Adults With Any Mental Illness (AMI); 2) Adults With Substance Use Disorder in the Past Year; 3) Adults With Serious Thoughts of Suicide; 4) Youth With At Least One Major Depressive Episode (MDE) in the Past Year; 5) Youth With Substance Use Disorder in the Past Year; 6) Youth With Severe MDE; 7) Adults With AMI Who Did Not Receive Treatment; 8) Adults With AMI Reporting Unmet Need; 9) Adults With AMI Who Are Uninsured; 10) Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs; 11) Youth With MDE Who Did Not Receive Mental Health Services; 12) Youth With Severe MDE Who Received Some Consistent Treatment; 13) Children With Private Insurance That Did Not Cover Mental or Emotional Problems; 14) Students Identified With Emotional Disturbance for an Individualized Education Program; and 15) Mental Health Workforce Availability.

Such measures become important toward generating a picture of mental health in expanded ways. Thus, identifying as the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health, the overall focus of MHA is as follows: 1) To provide a snapshot of mental health status among

youth and adults for policy and program planning, analysis, and evaluation; 2) To track changes in the prevalence of mental health issues and access to mental health care; 3) To understand how changes in national data reflect the impact of legislation and policies; and 4) To increase dialogue with and improve outcomes for individuals and families with mental health needs.

To that end, MHA offers useful insights regarding the state of mental health within America and how those areas can be used to advance strategic efforts toward improving the overall health and well-being of the population served. Following are critical findings from this report (MHA, 2022):

- 4.58% of adults report having serious thoughts of suicide;
- 8.1% of children had private insurance that did not cover mental health services;
- 10.6% of American youth have severe major depression;
- 15.8% of youth experienced a major depressive episode in the past year;
- 19.86% of American adults experienced some type of mental illness;
- 24.7% of adults with a mental illness report an unmet need for treat;
- 27% of youth with severe depression receive consistent care and in states with the least access, only 12% receive consistent care;
- Over 60% of youth with major depression do not receive any mental health treatment; and
- More than half of adults with mental illness do not receive treatment.

Findings from the MHA report highlight how Americans are facing mere thoughts of suicide and while it is near 5%, that percentage is significant given the implications of how thoughts lead to action, which, in this case, would be suicide. Findings from the MHA report also indicate how youth are dealing with depression and they are not receiving the appropriate treatment. This

becomes critical given the need to intervene early. If early intervention does not occur, then, in many ways, the absence or lack of intervention for depression becomes the precursor for suicide. Findings from the MHA report further show the gapping need of insurance companies to address the mental health services. Insurance companies are not providing funding for these needs in the manner needed by the constituencies served. Again, if the types of mental health services are not provided to address underlining needs, then unfortunately, suicide may become the preferred approach by those who are affected by these conditions.

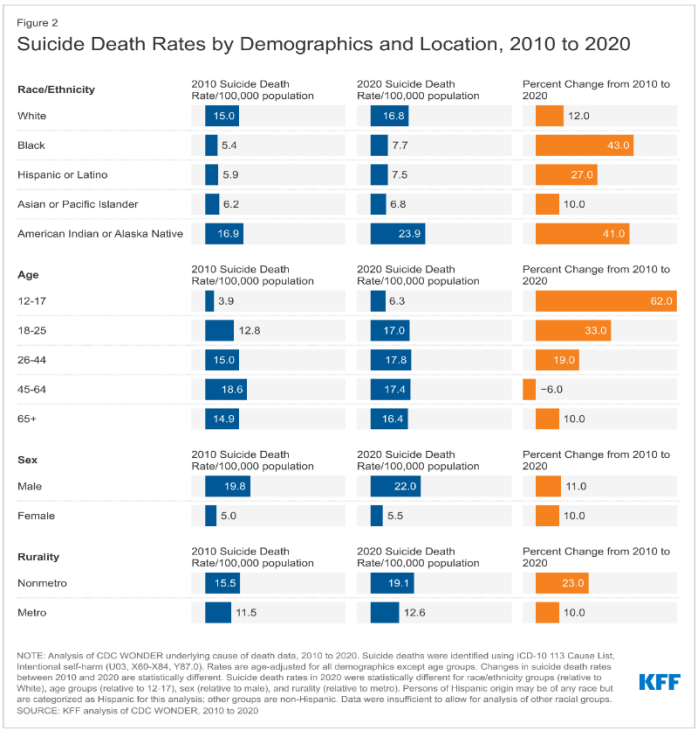


Figure 2

Suicide Death Rates by Demographics and Location, 2010 to 2020

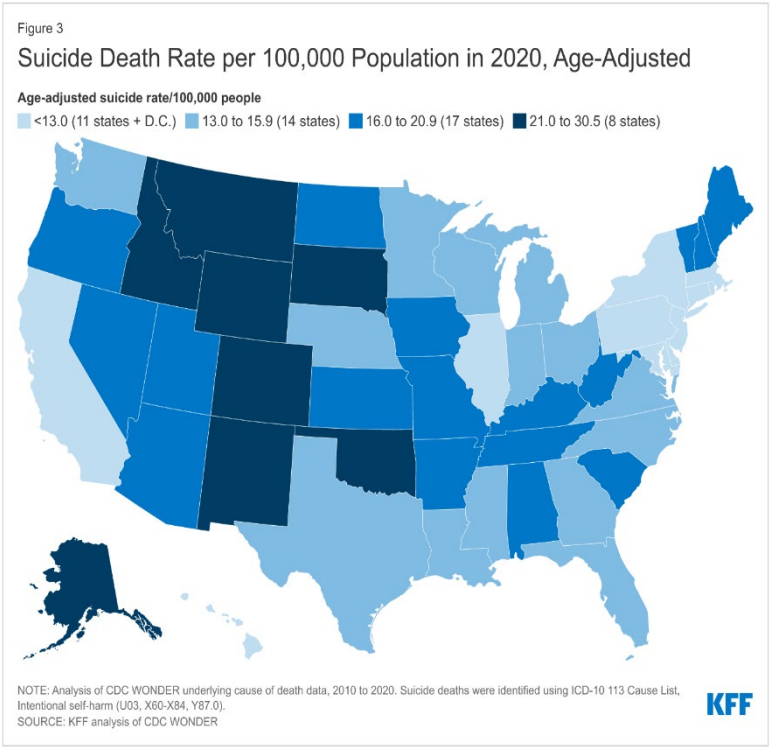
Race/Ethnicity	2010 Suicide Death Rate/100,000 population	2020 Suicide Death Rate/100,000 population	Percent Change from 2010 to 2020
White	15.0	16.8	12.0
Black	5.4	7.7	43.0
Hispanic or Latino	5.9	7.5	27.0
Asian or Pacific Islander	6.2	6.8	10.0
American Indian or Alaska Native	16.9	23.9	41.0
Age	2010 Suicide Death Rate/100,000 population	2020 Suicide Death Rate/100,000 population	Percent Change from 2010 to 2020
12-17	3.9	6.3	62.0
18-25	12.8	17.0	33.0
26-44	15.0	17.8	19.0
45-64	18.6	17.4	−6.0
65+	14.9	16.4	10.0
Sex	2010 Suicide Death Rate/100,000 population	2020 Suicide Death Rate/100,000 population	Percent Change from 2010 to 2020
Male	19.8	22.0	11.0
Female	5.0	5.5	10.0
Rurality	2010 Suicide Death Rate/100,000 population	2020 Suicide Death Rate/100,000 population	Percent Change from 2010 to 2020
Nonmetro	15.5	19.1	23.0
Metro	11.5	12.6	10.0

NOTE: Analysis of CDC WONDER underlying cause of death data, 2010 to 2020. Suicide deaths were identified using ICD-10 113 Cause List, Intentional self-harm (U03, X60-X84, Y87.0). Rates are age-adjusted for all demographics except age groups. Changes in suicide death rates between 2010 and 2020 are statistically different. Suicide death rates in 2020 were statistically different for race/ethnicity groups (relative to White), age groups (relative to 12-17), sex (relative to male), and rurality (relative to metro). Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Data were insufficient to allow for analysis of other racial groups.
SOURCE: KFF analysis of CDC WONDER, 2010 to 2020

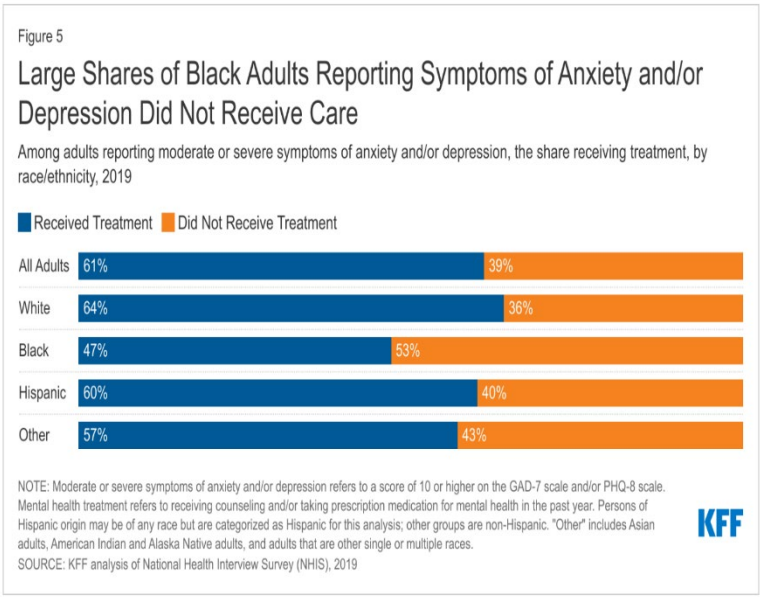
KFF

The Kaiser Family Foundation (2022) from 2010 to 2020, as shown in the extracted map of Figure 2 from the report, shows how suicide death rates increased substantially among people of color, with the highest increase among Black people (43% increase, from 5.4 to 7.7 per 100,000), followed by American Indian or Alaska Native (41% increase, from 16.9 to 23.9 per 100,000), and Hispanic (27% increase, 5.9 to 7.5 per 100,000).

The Kaiser Family Foundation (2022) offered an analysis of suicide death rate by state, as shown in the extracted map in Figure 3. What the report indicates is that of the states reporting the highest suicide death-rates (21 to 30 suicides per 100,000 in the population), only three (3) of the seven (7) reported state health agencies providing treatment or prevention activities, the states with the second highest suicide rate (16 to 20 per 100,000 in population) reported just six (6) of 17 agencies providing treatment or prevention activities. Likewise of the states with the third highest suicide rate, 13 to 15.9 suicides per 100,000, a mere three (3) of 14 had state agencies providing activities related to treatment or prevention.



More specifically, as indicated in Figure 5 of the extracted map, the Kaiser Family Foundation and the analysis of the 2019 National Health Interview Survey, reveals how Black and Latinos did not receive treatment for anxiety or depression compared to other racial or ethnic groups. The findings revealed similar reporting of moderate to severe symptoms of anxiety



and depression symptoms across all racial groups however, "…receipt of treatment varied considerably – compared to White adults (36%).

The Mental Health Alliance (2022) suggests that "a comprehensive 988 crisis system necessitates: training call staff to provide empowering, linguistically, and culturally appropriate supports to callers, ensuring the inclusion of appropriate care for subpopulations…" (p. 23). MHA acknowledges that successful 988 implementation will require state legislation to fund an adequate 988 infrastructure. Sadly, according to MHA's analysis of the 13 bottom ranked states with the highest rates of suicidal thoughts, "only four states passed laws for 988 implementation: Utah, Oregon, Indiana, and Colorado with only Utah including fees." MHA also designates Youth Mental Health as a priority and reports "While rates of mental health treatment are low for all youth with major depression, youth of color are significantly less likely to receive depression treatment than white youth." (p. 36). Because youth of color typically receive mental health services in schools, MHA recommends a series of policies to improve access to metal health services through education legislation.

Additionally, from a state-based perspective, the Association of States and Territories Health Officials (ASTHO, 2022) presents data on every state health agency in the United States. ASTHO provides an interactive online dashboard which shows the states' health agencies and how they are responding to mental illness treatment or mental illness prevention related activities. Findings indicate the number of state health agencies providing treatment activities decreased from eleven (11) states in 2016 to only six (6) states in 2019. Those six states included Nevada, Texas, Oklahoma, Iowa, Michigan, and Ohio. ASTHO (2022) also reports the number of state health agencies providing prevention activities decreased from twelve (12) in 2016 to eight (8) in 2019. Those states included Montana, Nevada, Utah, Colorado. Oklahoma,

Michigan, New Hampshire, and Maine. The small number of state health agencies addressing mental health needs compared to the high need for mental health services, illustrates broadly the present mental health crisis in the United States.

The National Alliance on Mental Illness (2022) report that only one in three Black adults with mental illness receive treatment. According to the American Psychiatric Association's *Mental Health Facts for African Americans Guide*, as identified by the National Alliance on Mental Health (2022), African Americans are: 1) Less likely to receive guideline-consistent care; 2) Less frequently included in research; and 3) More likely to use emergency rooms or primary care (rather than mental health specialists). For Latinos, The National Alliance on Mental Illness (2022) report that only more than half of Hispanic young adults ages 18-25 with serious mental illness may not receive treatment. This inequality puts these communities at a higher risk for more severe and persistent forms of mental health conditions, because without treatment, mental health conditions often worsen. More specifically, a total of 35.1% of Hispanic/Latinx adults with mental illness receive treatment each year compared to the U.S. average of 46.2%. Such findings indicate the lacking availability of mental health treatment for African Americans and Latinos.

WHAT WE NEED TO DO: INITIATIVE

What we need to do requires an initiative-oriented response given the aforementioned perspectives that not only have demonstrated the importance of having informed perspectives, but also the need to have practical approaches to address mental health matters within African American and Latino communities. Such approaches need to be responsive to *inter*- and *intra-contextual needs*. In effect, both the *inter*- and *intra*-contextual needs focus on addressing the issues of perceptions and impact of mental health in African Americans and Latinos and faith-

based and broader communities. Thus, the National Black Mental Health Program consists of three fundamental elements: Education (*knowledge*), Intervention (*mediators*) and Support (*practices*). Following below are approaches that comprise the NBCI program given what we know and what we need to do *inter*- and *intra*-contextually:

Table 2: What We Know and What We Need to Do for Mental Health Awareness

What We Know	**What We Need To Do**
The Importance of Education	Utilize mental health literature and video materials to prepare professional clinicians with the appropriate leadership knowledge to prepare clinicians with relevant administrative skills; Integrate of a Mental Health Dashboard where constituencies can determine their quality of mental health; Disseminate resource materials for educating church clergy and lay persons about mental health to ensure their knowledge of referral processes for intervention; and Implement the 'train the trainer' approach to ensure the sustainability of learning.
The Impact of Intervention	Provide early intervention to prevent escalation to crisis level issues; Offer comprehensive intervention approaches utilizing professionals with the following expertise: ➢ Life Coaching Sessions ➢ Individual and Group Counseling Sessions ➢ Individual and Group Therapy Sessions ➢ Talk Therapy ➢ Family Therapy ➢ Couples Therapy ➢ Teletherapy access when needed

	Implement emergency intervention protocols (i.e. referral for emergency or long-term treatment).
The Intricacies of Support	Demonstration and integration of prayer and other faith practices (i.e. meditation) as a resource for supporting mental health needs; Include resource listing of mental health professionals for social and related medical needs; and Promote *Mental Health Sundays* as a mechanism to prioritize the importance of mental health and well-being for congregations.

Table 2 outlines the education, implementation, and support necessary to address the needs of African Americans and Latinos regarding mental health.

To that end, given the level of commitment toward mental health within African American and Latino communities, what we need to do emerges in how NBCI anticipates spending $3 to $5 million dollars over the next two years to launch the aforementioned NBCI Mental Program in 1,000 churches. Depending on their size and resources, a total of 500 churches will be designated as primary program locations and 500 churches will be designated as secondary. The expected impact of access to quality mental health services is improved mental health outcomes for 200,000 to 350,000 African Americans and Latinos living in communities within NBCI's sphere of influence. More specifically, to achieve such outcomes in what it needs to do, NBCI seeks to implement the Mental Health Program by fostering buy-in from African American and Latino Mental Health Professionals who will provide research-based, data driven, mental health interventions to its congregants with the utmost confidentiality. Thus, NBCI's Mental Health Program will provide a top to bottom collection of organizational and individual professional resources, including training to develop culturally competent mental

health clinicians as well as provide ongoing mental health education to its members and the public.

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