CHAPTER 3

UNMET NEED FOR PUBLIC MENTAL HEALTH SERVICES

HOW MANY PEOPLE NEED PUBLIC MENTAL HEALTH SERVICES BUT ARE NOT RECEIVING THEM?

In October 2002 the President's New Freedom Commission on Mental Health revealed that in our nation one out of every two persons who needs mental health treatment does not receive it. For ethnic and racial minorities, groups that comprise a significant segment of California's population, the situation is even worse. As reported in 2001 in the Surgeon General's Report, "Mental Health: Culture, Race, and Ethnicity," ethnic and racial minorities receive treatment at a rate that is even lower than that of the general population. In addition, ethnic minority populations bear a greater burden from unmet mental health needs and suffer a greater loss to their overall health and productivity.

The responsibility of California's public mental health system is to serve children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses who are eligible for publicly funded mental health services. The *California Mental Health Master Plan* tries to do for this state what the President's Commission has done for the nation by estimating the unmet need for mental health services among children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses in California.

Approximately 600,000 adults, older adults, and children and youth in need of mental health treatment are not receiving services. In round numbers, this figure breaks down to 300,000 children and youth, 200,000 adults, and 100,000 older adults. To put this figure in perspective, approximately 460,000 persons were served by the public mental health system in fiscal year 1997-98[1]. Thus, the public mental health system would need to more than double to meet the needs of all children and youth with serious emotional disturbances and adults and older adults with serious mental illness.

A crisis also exists in access to mental health care for persons who are indigent. In 2003 the Department of Mental Health issued a report pursuant to AB 328 (Salinas) outlining, among other things, changes in the current service delivery system of mental health programs that have occurred since the enactment of realignment. The report notes that, in fiscal year 1990-91, 45 percent of the clients in the mental health system were Medi-Cal beneficiaries and 55 percent were indigents. In contrast, in fiscal year 1999-00, 68 percent were Medi-Cal beneficiaries and 38 percent were indigents. During that same period, the number of Medi-Cal clients served increased by 131 percent, and the number of indigents served has decreased by 8 percent. In the years since fiscal year 1999-00, the availability of services for indigents has only gotten worse. For example, in Los Angeles County many organizations have limited access for adults and older adults to only emergency care. During the last several years, organizations have turned away several thousand indigent clients because these organizations did not have the fiscal resources.

The personal loss represented by unmet need for mental health services and the crisis in access to services is brought into focus when one considers the advancements that have been made in understanding the nature of mental illness over the last two decades. Many effective treatments, both in terms of medication and psychosocial rehabilitation, have been found for major mental illnesses. Innovative programs, such as wraparound programs and strengths-based, family focused treatment planning, have brought breakthroughs in services to children and their families. When the public mental health system is not able to provide mental health services to children and youth, adults, and older adults in need, these individuals experience needless human suffering and lose the opportunity to achieve their full potential as human beings.

To develop long-range plans for improving the mental health system, policymakers and advocates need an estimate of the number of

[1] These unmet need calculations were made in fiscal year 1999-2000. At that time, the most recent data available on the number of clients served in the mental health system was for fiscal year 1997-98.

persons in need of mental health services from the public sector but who are not presently accessing those services. A number of methodologies exist for estimating how many people need public mental health services. The California Mental Health Planning Council (CMHPC) has reviewed several of these methodologies and applied them to California's population. Estimates using various assumptions are provided in this chapter. For statewide planning purposes, however, we believe that a reasonable estimate of unmet need for public mental health services is approximately 600,000 persons. Table 1 presents a summary of all the estimates in the chapter. These estimates vary from 436,435 to 2,027,157 depending on the assumptions used to generate the estimate.

Providing estimates of unmet need for mental health services assists county mental health programs and local mental health boards by giving them quantitative data necessary for advocating for increased state and federal funding for mental health services and efficiently distributing resources to address unmet needs. Additionally, due to a variety of factors, including human resource shortages, geographic location, population growth rates, and socioeconomic status, some counties have more difficulty providing services to their persons in need. These estimates also show which counties and regions are experiencing the most difficulty providing services to persons in need.

Table 1: Summary of Unmet Need Estimates by Age Group

Age Group	Lower Limit CMHS[1]	Lower Limit CMHS[2]	Lower Limit Meinhardt[1,3]	Lower Limit Meinhardt[2,3]
0-17	123,592	271,978	123,592	271,978
18-20	28,888	28,888	33,339	33,339
21-59	191,913	191,913	239,963	239,963
60+	92,042	92,042	104,164	104,164
Total	436,435	584,821	501,058	649,444
Age Group	**Upper Limit CMHS[1]**	**Upper Limit CMHS[2]**	**Upper Limit Meinhardt[1,3]**	**Upper Limit Meinhardt[2,3]**
0-17	493,593	864,000	493,593	864,000
18-20	76,889	76,889	87,925	87,925
21-59	699,403	699,403	820,316	820,316
60+	225,145	225,145	254,916	254,916
Total	1,495,030	1,865,437	1,656,750	2,027,157

[1] Unmet need for 0-17-year-olds is calculated based on children with SED and extreme functional impairment.
[2] Unmet need for 0-17-year-olds is calculated based on children with SED and substantial functional impairment.
[3] Meinhardt's estimates do not apply to 0-17-year-olds. In order to estimate total unmet need for all age groups, Meinhardt's prevalence rates were used for transition-age youth, adults, and older adults, and CMHS figures have been used for the 0-17-year-olds.

HOW WERE THE ESTIMATES DEVELOPED?

The CMHPC worked with the California Department of Mental Health (DMH) and the California Mental Health Directors Association (CMHDA) for more than a year to develop these estimates. The methodology draws on sound existing research and adapts the findings of that research to current conditions in both rural and urban regions of California. The initial draft was reviewed by the CMHDA Governing Board. Subsequently, county mental health directors were asked to comment on the estimates for their counties. The CMHPC's

Policy and System Development Committee reviewed the comments and decided how to incorporate them into the methodology. The CMHPC Children and Youth Committee reviewed the methodology for estimating unmet need among children with serious emotional disturbances (SED).

WHAT ARE THE LIMITATIONS OF THESE ESTIMATES?

Although the CMHPC tried to develop the most valid methodology possible given available data, any method for estimating unmet need has limitations that must be carefully considered when evaluating the results of the study. The following list enumerates those limitations.

1. Both the Meinhardt prevalence rates and the CMHS rate are derived from household surveys. As a result, they exclude the homeless and people in nursing homes, military barracks, correctional institutions, hospitals, and residential facilities for persons who are mentally ill or mentally retarded (Center for Mental Health Services, 1999, page 33895). Fischer and Breakey (1991) suggest that these groups constitute about five million people, or 2.7 percent of the U.S. adult population (Center for Mental Health Services, 1999). They estimate that the SMI prevalence rate for these groups is 50 percent. Because prevalence estimates do not include these segments of the population with the highest risk of SMI, the unmet need is underestimated.
2. San Francisco County has pointed out that a significant number of people drift into the county after acquiring a mental illness. Forty-five percent of mental health clients admitted to the inpatient unit at San Francisco General Hospital had arrived in San Francisco within two months of the admission (Presson, 2000).
3. People who have a mental illness resulting from HIV infection may not be included in prevalence rates (Presson, 2000).
4. Ethnic populations may be hesitant to report mental illness and to seek services. Although the ECA study does account for differences in reporting rates for non-Hispanic whites and all ethnic minorities, it does not make more detailed distinctions. This study used prevalence rates based on the ECA catchment data rather than more recent studies done that estimate the prevalence of mental illness for each racial, ethnic, and cultural population.
5. Meinhardt's county-specific prevalence rates are based on the counties' 1980 socio-demographic variables. Because of the increase in population, especially among non-white groups, from 1980 to 1990 they required adjustment upward to reflect increased population levels. This adjustment may not entirely account for differential migration by age or socio-demographic status (Meinhardt, Spitznagel, & Jerrell, 1990, page 17).
6. SED prevalence rates apply to children from 9 to 17 years of age. According to Friedman et al. (1996), "the data are presently inadequate to estimate prevalence rates for children under the age of nine" (page 84). Some studies have suggested prevalence rates of 7 to 22 percent for younger children (Knitzer, 2000). However, no reliable estimates are available for this age group. The CMHPC methodology most likely provides a conservative estimate for this age group.
7. Unmet need reflects the number of people who are not getting any mental health services at all. It does not reflect the number of people who are underserved.

HOW CAN UTILIZATION OF PRIVATE SECTOR MENTAL HEALTH SERVICES BE ESTIMATED?

Some clients access mental health services through the private sector. Because the CMHPC does not want to overstate unmet need for public services, a method for estimating private sector utilization had to be developed. Several studies offer estimates of the proportions of people with serious mental illnesses (SMI) who access services through the private sector. For example, Meinhardt, et al.

(1992) found that of children and youth treated for SED over a 12-month period 63.8 percent primarily used private services. The rest, 36.2 percent, relied on the public system. According to the same study, 57.9 percent of persons treated for SMI over a 12-month period used private services. The public system served the remaining 42.1 percent. Meinhardt et al.'s estimates were made in 1994, however, and many changes have occurred in the mental health system since that time. Some professionals in the field believe that the proportion of persons accessing the public system is now much greater than these estimates. For example, in a national study of mental health care use, Pacula and Sturm (2000) found that 65 percent of all persons with SMI living in the community accessed services through the public system; however, the sample size for California was too small to generalize the results to the state level (Pacula & Sturm, 2000).

Private sector access will also be affected by enactment of parity legislation. Many states have recently passed mental health parity mandates that require insurance coverage for mental illnesses to equal that for physical ailments. In California, Chapter 534, Statutes of 2000 (AB 88, Thomson) requires health care service plan contracts to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions. These benefits include outpatient services, inpatient hospital services, partial hospital services, and prescription drugs. The maximum lifetime benefits, co-payments, and deductibles applied to serious mental illness must be the same as those applied to other illnesses.

However, a nationwide study, Pacula and Sturm (2000) found that "those states that are able to pass parity legislation do not experience significant increases in the utilization of mental health services. This may be due in part to a loss of coverage for those people most at risk for mental health disorders" (Pacula & Sturm, 2000, p. 263). In California, however, most people who have private insurance are part of a group plan, and are unlikely to be dropped as a result of the new legislation. Indeed, two of the State's largest providers, Kaiser and PacifiCare, are already in the process of hiring new mental health professionals to accommodate the anticipated increase in demand for their behavioral health care services.

Understanding access to the private sector is a crucial issue for mental health planning. Considerable uncertainty about how to estimate private sector utilization exists due to changes in the mental health system since Meinhardt et al.'s study was done in 1992, California's increasing growing diversity, and how the enactment of the parity legislation will affect access to the private system.

The issue of disparities in mental health care is gaining national attention. More studies are documenting disparities in quality, availability, and service utilization rates of mental health care for racial, cultural, and ethnic populations. The methodology used in this chapter to estimate unmet need did not employ prevalence rates specific to each ethnic group. In addition, the Meinhardt et al. study about access to private sector services did not report access rates by ethnicity. Consequently, the findings of unmet need do not reflect disparities in access to mental health services for racial, cultural, and ethnic populations.

3.1. Recommendation: The State Department of Mental Health should commission a new study in fiscal year 2003-04 to determine the proportion of adults with SMI and children with SED in each major ethnic group who are able to access services in the private sector.

3.2. Recommendation: Once the DMH completes the recommended study of access to private sector mental health services for each major ethnic group, the CMHPC should update the determination of unmet need generating estimates for each ethnic group using prevalence rates identified for those groups.

WHAT IS THE CMHPC'S METHODOLOGY FOR DETERMINING UNMET NEED?

Children and Youth

Estimated Prevalence of Serious Emotional Disturbance

To determine unmet need, the number of children and youth with SED had to be estimated. This process was difficult for a variety of reasons. No reliable prevalence data

exist for children under the age of nine (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996, page 84). For children between the ages of 9 and 17, prevalence estimates vary. Variability in the prevalence estimates can be attributed, in part, to differing definitions of SED. Often, the question is not only "Who has a diagnosable disorder?" but also "Who are we required to serve?" Four different state and federal definitions need to be considered in evaluating the prevalence rate to use for children and youth: the eligibility criteria for Early, Periodic, Screening, Diagnoses, and Treatment (EPSDT), the California Welfare and Institution Code (WIC) target population definition for children and youth, the federal CMHS definition of serious emotional disturbance, and finally the definitions CMHS workgroups used to establish specific prevalence rates.

The first definition for EPSDT eligibility is quite broad. California Code Title 22 §51340 requires county mental health programs to treat all children under age 21 who have a mental illness that can be corrected or ameliorated with treatment, whose treatment requires specialty mental health services, and who qualify for full-scope Medi-Cal benefits.

The second definition for the target population for realignment funds and Children's System of Care services is narrower. The state WIC §5600.3 (a) defines target populations that should be given first priority for receiving services. WIC §5600.3 (a) (2) defines the children's target population as follows:

> For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:
>
> (A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
>
> (i) The child is at risk of removal from home or has already been removed from the home.
>
> (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
>
> (B) The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
>
> (C) The child meets special education requirements according to Chapter 26.5 (commencing with §7570) of Division 7 of Title 1 of the Government Code.

The third definition was established by the CMHS, which allocates federal funds to states through block grants for provision of community mental health services. The CMHS is required by law to establish a definition of SED and a method for making estimates of the overall prevalence in the population, and states then use these estimates as part of their application for funds under the block grant program. The CMHS (1996) defines SED as follows:

> Children from birth to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual (DSM)-III-R* and that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. These disorders include any mental disorder (including those of a biological etiology) listed in *DSM-III-R* or their

> *International Classification of Disease (ICD)-9-CM* equivalent (and subsequent revisions) with the exception of *DSM-III-R* 'V' codes, substance abuse, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance (Friedman et al., 1996, page 72).

Functional impairment is defined as follows:

> Difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included, unless they are temporary and expected responses to stressful events in their environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition (Friedman et al., 1996, page 72).

A CMHS work group reviewed a number of studies estimating the prevalence of children exhibiting various levels of functional impairment. The Children's Global Assessment Scale (CGAS) was the most commonly used instrument in these studies. The CGAS rates children's level of functioning on a scale from 0 to 100 with narrative descriptions of functioning at various levels. Lower scores indicate greater impairment. The work group decided to establish two levels of functional impairment based on the CGAS. Both levels meet the CMHS definition of "seriously emotionally disturbed."

The work group estimated that 5 to 9 percent of all children between the ages of 9 and 17 have a serious emotional disturbance and a level of functioning equal to or below a score of 50 on the CGAS. These children are said to exhibit "extreme functional impairment." The narrative description for a score of 50 or lower is as follows:

> Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other anti-social behavior with some preservation of meaningful social relationships (Friedman et al., 1996, page 74).

The work group found that 9 to 13 percent of all children between the ages of 9 and 17 have a serious emotional disturbance and a level of functioning equal to or below a score of 60 on the CGAS. The narrative description for a score of 60 is as follows:

> Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in settings where functioning is appropriate (Friedman et al., 1996, page 74).

Using this more inclusive criterion for functional impairment, 9 to 13 percent of all children are categorized as having a serious emotional disturbance accompanied by "substantial functional impairment." The CMHS definition of SED includes children with difficulties that substantially interfere with a child's functioning. Children with extreme impairment are subsumed in the substantial functional impairment definition of SED. The CMHS recommends that, from the standpoint of planning service needs, the 9-13 percent range should be used; however, according to the CMHS work group, "the…more conservative estimate can be used for more targeted efforts to plan on behalf of a more limited number of children whose level of functional impairment is especially severe" (Friedman et al., 1996, page 73).

The CMHPC decided to estimate the number of children suffering from SED based on both the CMHS prevalence rates for children with extreme functional impairment and for children with substantial functional impairment. Initially, the CMHPC only calculated unmet need using the more conservative prevalence estimates. Using the conservative range still produced very high estimates of unmet need: between 127,936 and 498,370 youth with

extreme functional impairment are not receiving any services at all. Some CMHPC members felt that presenting the conservative figures would be more effective and would allow for extrapolation. The alternative is to offer the more inclusive figures and run the risk that they will be considered inflated. However, some members pointed out that under EPSDT legislation counties are mandated to serve all children who meet the criteria for "medical necessity" in addition to those in the DMH target population. Children who have a substantial impairment according to the CMHS definition are likely to meet the EPSDT criteria for medical necessity. Thus, the higher figure based on the substantial functional impairment definition is also justified.

In addition to being a function of definition, prevalence rates are also affected by socioeconomic status. The CMHS work group found that the prevalence rate is higher for children living in low socioeconomic circumstances and makes the following recommendations:

> States with a poverty rate more than five percent higher than the national average should use an estimate at the upper end of the prevalence range provided here (13 percent), and States with a poverty rate of more than 2.5 percent but less than 5 percent higher than the national average should use a prevalence estimate of 12 percent. Similarly, States with a poverty rate more than five percent below the national average should use a prevalence estimate at the lower end of the range (9 percent), and States with a poverty rate between 2.5 percent and 5 percent lower than the national average should use a prevalence estimate of 10 percent. States within 2.5 percent of the national average should use estimates in the middle of this range (11 percent) (Friedman et al., 1996, page 85).

The CMHPC heeded the recommendation of the CMHS to account for the impact of poverty on mental health. The methodology developed by the CMHS was applied to each county using both the 9 to 13 percent prevalence rate range and the more conservative range of 5 to 9 percent. Table 2 shows the prevalence rates used for each county. The lowest rate in each range (5 percent for the conservative range and 9 percent for the more inclusive range) was applied to 12 counties with poverty rates ranging from 5.2 percent to 8.4 percent. The 6 percent and 10 percent rates were applied to 8 counties with poverty rates between 8.5 percent and 10.7 percent. The 7 percent and 11 percent rates were applied to 24 counties with poverty rates ranging from 11.3 to 15.7 percent. The 8 percent and 12 percent rates were applied to eight counties with poverty rates ranging from 16.9 percent to 18.5 percent. The remaining six counties, with poverty rates ranging from 18.9 percent to 23.8 percent, were estimated to have a 9 percent or 13 percent prevalence rate. For example, in Imperial County, the poverty rate (23.8 percent) is 10.3 percentage points higher than the national average (13.5 percent), so a 9 percent prevalence rate (or 13 percent from the more inclusive view) is assumed. In contrast, Marin County has a poverty rate of 5.2 percent, so a 5 percent prevalence rate (9 percent using the more inclusive range) is assumed. The population figures of children age 0-17 in each county (see Table 3) were multiplied by the corresponding prevalence rates to estimate the number of SED children with extreme functional impairment and with substantial functional impairment.

Number of Children and Youth Needing Public Mental Health Services

As already mentioned, some children with SED receive services from private providers. Currently, Meinhardt et al.'s 1994 study provides the most accurate data applicable to California. The CMHPC believes that the DMH must commission a study to update the percentage of children with SED who rely on the public sector for services. In order to account for the changes to the mental health system since Meinhardt's study, the CMHPC has provided a range for the number of children needing public services. To find the lower end of the range, the estimated number of children with SED was multiplied by 36.2 percent, the proportion of children expected to need public mental health services according to the Meinhardt study. The upper limit of the range is simply the estimated number of children with SED. This upper limit reflects the number of children who would need public services if no private services were available. For counties with populations under 200,000, a lower

estimate was not calculated based on the assumption that a full range of private mental health services are not available in rural areas.

Unmet Need Calculation

The DMH provided the CMHPC with the number of clients served for fiscal year 1997-1998. In order to determine unmet need, the number of children served was subtracted from both the lower estimate and the upper estimate of children needing public mental health services. Table 2 shows the estimated number of children with extreme functional impairment who are not receiving services and the estimated number of children with substantial functional impairment who are not receiving services. The number of unduplicated clients reported by the DMH from the Client Data System excludes children with only one outpatient visit or only one inpatient visit less than four days. These exclusions were applied to the data so that the clients included in the utilization data were more likely to be long-term recipients of services as opposed to those needing only brief services.

Transition-Age Youth, Adults, and Older Adults

Estimated Prevalence of Serious Mental Illness

According to epidemiological studies, 6 percent of California's population suffers from schizophrenia, bipolar disorder, or major depression (Meinhardt et al., 1990). An estimated 13 percent have a diagnosis of dysthymia, panic disorder, phobia, obsessive-compulsive disorder, or antisocial personality disorder (Meinhardt et al., 1990). However, as with children, the question is often not "Who has a diagnosable disorder?" but "Whom are we required to serve?" California's WIC §5600.3 (b) defines the target population to be served by the public mental health system as follows:

> For the purposes of this part, "serious mental disorder" means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

Table 2: Prevalence Rates and Unmet Need Estimate for Ages 0-17 by County

COUNTY	SED with extreme functional impairment			SED with substantial functional impairment		
	Prevalence Rate	Lower Limit	Upper Limit	Prevalence Rate	Lower Limit	Upper Limit
Statewide		**123,592**	**493,953**		**271,978**	**864,000**
Alameda	6%	5,002	18,926	10%	10,269	33,475
Alpine	8%	10	10	12%	19	19
Amador	5%	204	204	9%	464	464
Butte	9%	3,117	3,117	13%	5,089	5,089
Calaveras	6%	353	353	10%	704	704
Colusa	7%	296	296	11%	520	520
Contra Costa	5%	1,825	9,220	9%	5,182	18,491
Del Norte	7%	27	27	11%	312	312
El Dorado	5%	1,405	1,405	9%	2,913	2,913
Fresno	9%	5,902	20,547	13%	9,596	30,749
Glenn	1%	467	467	12%	792	792
Humboldt	8%	1,971	1,971	12%	3,239	3,239
Imperial	9%	3,295	3,295	13%	5,152	5,152
Inyo	7%	253	253	11%	428	428
Kern	8%	163	10,562	12%	3,113	18,712
Kings	8%	2,699	2,699	12%	4,177	4,177
Lake	7%	667	667	11%	1,199	1,199
Lassen	7%	285	285	11%	570	570
Los Angeles	7%	27,150	150,323	11%	67,086	260,643
Madera	8%	1,827	1,827	12%	3,163	3,163
Marin	5%	420	2,008	9%	1,141	4,001
Mariposa	7%	113	113	11%	254	254
Mendocino	7%	1,230	1,230	11%	2,123	2,123
Merced	9%	1,213	5,232	13%	2,227	8,032
Modoc	7%	68	68	11%	166	166
Mono	6%	151	151	10%	258	258
Monterey	7%	1,925	6,992	11%	3,568	11,530
Napa	5%	1,035	1,035	9%	2,179	2,179
Nevada	5%	741	741	9%	1,534	1,534
Orange	6%	8,657	37,298	10%	19,491	67,227
Placer	5%	637	2,458	9%	1,464	4,743
Plumas	7%	158	158	11%	338	338
Riverside	7%	4,400	23,444	11%	10,575	40,500
Sacramento	7%	3,729	18,169	11%	8,411	31,103
San Benito	6%	506	506	10%	1,056	1,056
San Bernardino	7%	6,565	30,116	11%	14,201	51,209
San Diego	7%	13,392	47,036	11%	24,300	77,169
San Francisco	7%	0	6,672	11%	2,264	12,515
San Joaquin	7%	1,904	9,275	11%	4,294	15,877
San Luis Obispo	7%	496	2,850	11%	1,259	4,958
San Mateo	5%	969	6,454	9%	3,459	13,333
Santa Barbara	7%	716	5,315	11%	2,207	9,435

Table 2 (cont'd): Prevalence Rates and Unmet Need Estimate for Ages 0-17 by County

COUNTY	SED with extreme functional impairment			SED with substantial functional impairment		
	Prevalence Rate	Lower Limit	Upper Limit	Prevalence Rate	Lower Limit	Upper Limit
Santa Clara	5%	3,071	16,853	9%	9,327	34,135
Santa Cruz	6%	417	2,828	10%	1,329	5,347
Shasta	7%	2,356	2,356	11%	4,085	4,085
Sierra	6%	24	24	10%	53	53
Siskiyou	7%	121	121	11%	549	549
Solano	5%	826	4,371	9%	2,435	8,817
Sonoma	5%	241	3,707	9%	1,814	8,053
Stanislaus	7%	1,133	7,060	11%	3,055	12,369
Sutter-Yuba	8%	2,640	2,640	12%	4,341	4,341
Tehama	7%	586	586	11%	1,157	1,157
Trinity	8%	187	187	12%	312	312
Tulare	9%	1,400	8,288	13%	3,137	13,086
Tuolumne	6%	304	304	10%	739	739
Ventura	5%	1,802	8,312	9%	4,757	16,474
Yolo	8%	2,541	2,541	12%	4,132	4,132

In 1990 the DMH funded Meinhardt, et al. to assess mental health needs throughout the State. The resulting study, *California Mental Health Needs Met by Local and State Hospital Services*, estimates county-specific prevalence rates of SMI. The rates are derived from the National Institute of Mental Health's Epidemiological Catchment Areas (ECA) Project. The ECA data were obtained through random household interviews in five sites in the United States. Interviews were conducted using the Diagnostic Interview Schedule (DIS), a highly structured interview that can be conducted by a trained non-professional. Interview results were analyzed to estimate the prevalence of disorders in the U.S. population as a whole. Since prevalence rates are affected by socio-demographic characteristics, Meinhardt determined the prevalence rate of each California county by adjusting the national prevalence figure to factors in each county's socio-demographic composition.

Meinhardt found that six percent of California's adult population suffers from schizophrenia, bipolar disorder, or major depression. The DMH estimates that one third of these adults, or two percent of the population, also has a major functional impairment related to the illness (California Department of Mental Health, 1999, page 116). This prevalence estimate is lower because the DMH does not include major depression as a diagnosis that would result in a major functional impairment.

In contrast, the federal CMHS estimates that 5.4 percent of adults suffer from a diagnosable mental disorder resulting in a serious role impairment (Center for Mental Health Services, 1999). The CMHS allocates federal funds to States through block grants for provision of community mental health services. The CMHS is required by law to establish a definition of SMI and a method for making estimates of the overall prevalence in the population. These estimates are then to be used by States as part of their application for funds under the block grant program.

The CMHS defines SMI as "the conjunction of a DSM mental disorder and a serious role impairment" (Center for Mental Health Services, 1999, page 33891). The following four criteria define SMI (Kessler et al., 1996, page 60-61):

1. A 12-month prevalence of schizophrenia, schizoaffective disorder, manic-depressive disorder, autism, and severe forms of major depression, panic

disorder, and obsessive-compulsive disorder. Severe forms of major depression and panic disorder are indicated by either hospitalization or the use of major psychotropic medications. This criterion includes people who would have been symptomatic in the absence of treatment.

2. Any DSM disorder in the past 12 months accompanied by planned or attempted suicide within the past 12 months.

3. Any DSM disorder in the past 12 months accompanied by a vocational capacity substantially below expected level of functioning. One group of people in this category consists of people who are unemployed or working part time, living below the poverty level, and whose background and education are such that they would be expected to have at least twice their actual incomes. Another group in this category consists of people with a 12-month DSM diagnosis who consistently miss at least one full day of work per month as a direct result of problems with their mental health.

4. Any DSM diagnosis and complete isolation or only having relationships that are devoid of intimacy, the ability to confide, or the sense of being cared for or supported.

For the purpose of this chapter, prevalence of SMI was estimated using both Meinhardt's county-specific prevalence rates and the standard rate published by the CMHS in the *Federal Register*. Some counties suggested using Kessler's 1997 report "Estimation of the 12-month Prevalence of Serious Mental Illness" (Kessler et al., 1997). However, Dr. Kessler's colleagues informed the CMHPC that they did not have much confidence in their county estimates because they lacked sufficient county-specific data.

The Meinhardt report (1990) provided county-specific rates for schizophrenia, bipolar disorder, and major depression. For each county, the combined county-specific rate for each of those illnesses (see Table 4) was multiplied by the population (see Table 3) for each adult age group, 18-21, 22-59, and 60 years and older. This calculation produced an estimate of the number of adults and older adults with SMI. The *Federal Register* estimates the 12-month prevalence rate of SMI to be 5.4 percent nationally (Center for Mental Health Services, 1999). The population figures for each age group (Table 3) were multiplied by 5.4 percent to provide another estimate of the number of adults and older adults with SMI (see Table 5).

Table 3: County Populations by Age Group for 1998

COUNTY	Total	0-17	18-20	21-59	60-UP
Statewide	**32,956,588**	**9,251,040**	**1,686,917**	**17,377,723**	**4,640,908**
Alameda	1,398,590	363,725	64,009	777,807	193,049
Alpine	1,205	237	70	737	161
Amador	33,430	6,495	1,501	16,881	8,553
Butte	198,484	49,307	9,793	95,375	44,009
Calaveras	37,894	8,756	2,090	17,385	9,663
Colusa	18,524	5,601	1,177	8,686	3,060
Contra Costa	896,214	231,790	43,829	481,816	138,779
Del Norte	28,391	7,106	1,691	14,452	5,142
El Dorado	147,386	37,711	7,814	76,525	25,336
Fresno	778,656	255,049	45,163	374,934	103,510
Glenn	26,889	8,144	1,646	12,444	4,655
Humboldt	126,070	31,696	6,719	67,563	20,092
Imperial	142,674	46,414	10,502	67,092	18,666
Inyo	18,264	4,384	973	8,436	4,471
Kern	634,333	203,751	35,779	308,832	85,971
Kings	117,747	36,952	7,303	61,106	12,386
Lake	55,034	13,313	2,845	23,690	15,186
Lassen	33,787	7,125	2,423	19,482	4,757
Los Angeles	9,524,767	2,758,008	452,579	5,089,394	1,224,786
Madera	113,462	33,404	7,384	54,960	17,714
Marin	243,301	49,809	9,336	141,363	42,793
Mariposa	15,976	3,507	776	7,623	4,070
Mendocino	85,956	22,340	5,068	43,438	15,110
Merced	201,962	69,993	12,229	94,802	24,938
Modoc	10,152	2,442	637	4,782	2,291
Mono	10,582	2,655	424	6,215	1,288
Monterey	377,828	113,458	19,966	194,652	49,752
Napa	121,093	28,615	5,862	62,481	24,135
Nevada	88,368	19,826	4,688	42,294	21,560
Orange	2,705,287	748,205	122,544	1,485,433	349,105
Placer	215,505	57,107	11,562	111,836	35,000
Plumas	20,422	4,491	1,228	9,576	5,127
Riverside	1,423,664	426,409	72,303	682,793	242,159
Sacramento	1,146,882	323,332	57,035	600,443	166,072
San Benito	46,151	13,738	2,746	22,985	6,682
San Bernardino	1,617,385	527,327	90,355	813,837	185,866
San Diego	2,763,318	753,323	171,187	1,451,288	387,520
San Francisco	777,492	146,077	27,748	456,108	147,559
San Joaquin	542,193	165,046	30,061	268,276	78,810
San Luis Obispo	234,661	52,698	19,353	118,847	43,763
San Mateo	711,723	171,964	30,165	390,218	119,376
Santa Barbara	400,788	102,989	26,975	207,291	63,533
Santa Clara	1,671,410	432,041	75,312	948,118	215,939
Santa Cruz	247,252	62,984	13,412	136,092	34,764
Shasta	163,254	43,205	9,322	80,023	30,704

Table 3 (cont'd): County Populations by Age Group for 1998

COUNTY	Total	0-17	18-20	21-59	60-UP
Sierra	3,412	742	173	1,645	852
Siskiyou	44,199	10,698	2,718	21,117	9,666
Solano	378,676	111,139	20,434	202,424	44,679
Sonoma	432,751	108,651	20,759	231,587	71,754
Stanislaus	425,316	132,715	24,618	208,906	59,077
Sutter-Yuba	137,302	42,513	7,565	65,992	21,232
Tehama	54,623	14,293	3,260	24,931	12,139
Trinity	13,245	3,118	765	6,453	2,909
Tulare	358,359	119,952	22,684	166,893	48,830
Tuolumne	52,151	10,855	2,941	26,178	12,177
Ventura	727,250	204,051	38,224	385,318	99,657
Yolo	154,898	39,764	17,192	77,868	20,074

Table 4: Unmet Need Estimate Based on Meinhardt's County-Specific Prevalence Rates

COUNTY	Prevalence Rate Used	18-20		21-59		60+	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Statewide		**33,339**	**87,925**	**239,963**	**820,316**	**104,164**	**254,916**
Alameda	6.53%	1,407	3,827	13,623	43,031	4,607	11,906
Alpine	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Amador	4.08%	46	46	424	424	321	321
Butte	6.06%	490	490	3,464	3,464	2,506	2,506
Calaveras	4.05%	68	68	432	432	363	363
Colusa	4.88%	51	51	274	274	131	131
Contra Costa	5.25%	673	2,003	5,517	20,135	2,565	6,775
Del Norte	5.28%	55	55	205	205	234	234
El Dorado	5.45%	378	378	3,344	3,344	1,319	1,319
Fresno	5.85%	540	2,070	1,665	14,365	1,819	5,325
Glenn	4.96%	60	60	249	249	201	201
Humbolt	6.59%	363	363	2,830	2,830	1,236	1,236
Imperial	5.83%	550	550	2,684	2,684	965	965
Inyo	4.62%	41	41	210	210	186	186
Kern	5.31%	426	1,526	1,192	10,687	1,519	4,162
Kings	5.78%	404	404	1,076	1,076	651	651
Lake	3.95%	85	85	420	420	548	548
Lassen	5.60%	108	108	796	796	255	255
Los Angeles	6.63%	9,101	26,474	81,365	276,735	27,710	74,726
Madera	5.10%	335	335	1,920	1,920	820	820
Marin	6.23%	202	539	2,409	7,508	999	2,543
Mariposa	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Mendocino	5.38%	227	227	1,524	1,524	756	756
Merced	5.85%	176	590	369	3,580	399	1,244
Modoc	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Mono	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Monterey	6.16%	441	1,153	3,690	10,633	1,174	2,949
Napa	4.95%	258	258	2,214	2,214	1,078	1,078
Nevada	4.34%	181	181	1,309	1,309	881	881

Table 4 (cont'd): Unmet Need Estimate Based on Meinhardt's County-Specific Prevalence Rates

COUNTY	Prevalence Rate Used	18-20		21-59		60+	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Orange	5.88%	1,896	6,068	19,996	70,567	6,919	18,804
Placer	4.93%	181	511	850	4,043	618	1,618
Plumas	4.61%	42	42	152	152	219	219
Riverside	5.00%	541	2,634	3,352	23,119	4,340	11,351
Sacramento	6.13%	1,146	3,170	8,213	29,524	3,657	9,551
San Benito	5.39%	118	118	883	883	328	328
San Bernardino	5.49%	1,330	4,202	7,041	32,911	3,577	9,485
San Diego	6.35%	3,617	9,911	17,000	70,359	8,505	22,753
San Francisco	7.84%	0	849	1,624	22,329	2,041	8,740
San Joaquin	5.49%	509	1,464	258	8,785	810	3,315
San Luis Obispo	6.50%	449	1,177	1,828	6,301	1,098	2,745
San Mateo	5.43%	449	1,397	4,380	16,648	2,026	5,779
Santa Barbara	6.35%	328	1,320	2,193	9,814	1,372	3,708
Santa Clara	6.11%	1,519	4,184	15,558	49,099	4,050	11,689
Santa Cruz	6.26%	237	724	1,906	6,838	675	1,935
Shasta	5.21%	381	381	1,787	1,787	1,437	1,437
Sierra	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Siskiyou	4.67%	88	88	81	81	369	369
Solano	5.46%	314	960	2,151	8,550	760	2,172
Sonoma	5.42%	325	976	2,490	9,758	1,253	3,505
Stanislaus	5.37%	339	1,104	580	7,075	881	2,717
Sutter-Yuba	5.62%	385	385	2,452	2,452	1,037	1,037
Tehama	4.47%	110	110	337	337	449	449
Trinity	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Tulare	5.41%	393	1,103	1,366	6,594	878	2,408
Tuolumne	4.93%	100	100	486	486	479	479
Ventura	5.37%	658	1,847	5,339	17,320	1,780	4,879
Yolo	7.83%	1,218	1,218	4,455	4,455	1,363	1,363

Table 5: Unmet Need Estimate Based on CMHS Prevalence Rate

COUNTY	18-20		21-59		60+	
	Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Statewide	**28,888**	**76,889**	**191,913**	**699,403**	**92,042**	**225,145**
Alameda	1,102	3,103	9,923	34,242	3,689	9,725
Alpine	2	2	23	23	9	9
Amador	66	66	647	647	434	434
Butte	426	426	2,834	2,834	2,215	2,215
Calaveras	96	96	667	667	494	494
Colusa	58	58	319	319	147	147
Contra Costa	702	2,073	5,842	20,906	2,658	6,997
Del Norte	57	57	222	222	241	241
El Dorado	374	374	3,305	3,305	1,306	1,306
Fresno	455	1,867	955	12,677	1,623	4,860
Glenn	67	67	304	304	221	221
Humbolt	283	283	2,026	2,026	997	997
Imperial	505	505	2,396	2,396	885	885
Inyo	49	49	276	276	220	220
Kern	439	1,558	1,309	10,965	1,551	4,239
Kings	376	376	844	844	604	604
Lake	127	127	763	763	768	768
Lassen	103	103	757	757	246	246
Los Angeles	6,757	20,907	55,010	214,135	21,367	59,661
Madera	357	357	2,085	2,085	874	874
Marin	169	461	1,915	6,335	850	2,188
Mariposa	32	32	191	191	199	199
Mendocino	228	228	1,533	1,533	759	759
Merced	153	535	189	3,153	352	1,132
Modoc	25	25	80	80	103	103
Mono	19	19	244	244	65	65
Monterey	377	1,001	3,067	9,153	1,015	2,571
Napa	285	285	2,495	2,495	1,186	1,186
Nevada	231	231	1,757	1,757	1,109	1,109
Orange	1,648	5,479	16,994	63,437	6,214	17,129
Placer	204	565	1,071	4,568	688	1,782
Plumas	51	51	228	228	260	260
Riverside	663	2,923	4,502	25,850	4,748	12,320
Sacramento	971	2,754	6,367	25,141	3,146	8,339
San Benito	118	118	885	885	329	329
San Bernardino	1,296	4,121	6,733	32,178	3,506	9,318
San Diego	2,933	8,285	11,196	56,572	6,955	19,071
San Francisco	0	172	0	11,200	526	5,139
San Joaquin	497	1,437	156	8,544	780	3,244
San Luis Obispo	359	964	1,278	4,994	895	2,263
San Mateo	445	1,388	4,330	16,531	2,011	5,743
Santa Barbara	220	1,064	1,364	7,845	1,118	3,105

Table 5 (cont'd): Unmet Need Estimate Based on CMHS Prevalence Rate

COUNTY	18-20		21-59		60+	
	Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Santa Clara	1,294	3,649	12,724	42,367	3,404	10,156
Santa Cruz	189	608	1,413	5,668	549	1,636
Shasta	398	398	1,939	1,939	1,495	1,495
Sierra	7	7	44	44	37	37
Siskiyou	108	108	235	235	440	440
Solano	309	947	2,100	8,429	749	2,146
Sonoma	323	972	2,471	9,712	1,247	3,491
Stanislaus	342	1,111	606	7,138	888	2,735
Sutter-Yuba	369	369	2,307	2,307	991	991
Tehama	140	140	569	569	562	562
Trinity	38	38	154	154	145	145
Tulare	392	1,101	1,359	6,577	876	2,403
Tuolumne	114	114	609	609	537	537
Ventura	663	1,858	5,388	17,435	1,793	4,908
Yolo	877	877	2,913	2,913	966	966

Each prevalence estimate has benefits and limitations. The CMHS rate is more current. In addition, comparisons with other states are possible using this standard rate. The Meinhardt data are useful because the rates are adjusted to account for county-level socio-demographic information.

Number of Persons Needing Public Mental Health Services

As already mentioned, some persons with SMI receive services from private providers. Currently, Meinhardt et al.'s 1994 study provides the most accurate data applicable to California. The CMHPC believes that the DMH must commission a study to update the percentage of persons with SMI who rely on the public sector for services. In order to account for the changes to the mental health system since Meinhardt's study, the CMHPC has provided a range for the number of persons needing public services. To find the lower end of the range, the estimated number of persons with SMI was multiplied by 42.1 percent, the proportion of adults expected to need public mental health services according to the Meinhardt study. The upper limit of the range is simply the estimated number of persons with SMI. This upper limit reflects the number of people who would need public services if no private services were available. For counties with populations under 200,000, a lower estimate was not calculated based on the assumption that a full range of private mental health services are not available in rural areas.

Unmet Need Calculation

The DMH provided the CMHPC with an unduplicated count of the number of clients served for fiscal year 1997-1998. In order to determine unmet need, the number of clients served was subtracted from both the lower end and the upper end of the estimated number of clients needing public mental health services. Tables 4 and 5 show the estimated range of clients suffering from SMI who are not receiving services. The unduplicated count of clients served excludes clients with only one outpatient visit or only one inpatient visit less than four days.

WHAT IS THE EXTENT OF UNMET NEED FOR PUBLIC MENTAL HEALTH SERVICES AMONG RACIAL/ETHNIC AND CULTURAL GROUPS?[2]

As noted in the Surgeon General's Supplement on Mental Health: Race, Culture, and Ethnicity, the causation of mental illness is a complex interaction among biological, social, and cultural factors (U.S. Department of Health and Human Services, 2001, p. 26). Considering the biological element, the report found that, "the overall prevalence rates for mental disorders in the United States are similar across minority and majority populations" (U.S. Department of Health and Human Services, 2001, p. 27). The report goes on to point out, however, that racial and ethnic minorities face a more stressful social and economic environment that increases the rate of mental disorders among those groups:

> Ethnic and racial minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health. Living in poverty has the most measurable impact on rates of mental illness. People in the lowest stratum of income, education, and occupation are about two to three times more likely that those in the highest stratum to have a mental disorder (U.S. Department of Health and Human Services, 2001, p. 42).

This section reports on the demographic and socio-economic factors that contribute to mental health needs and barriers to mental health services among African Americans, American Indians, Asian Americans and Pacific Islanders, and Hispanic/Latino Americans.[3]

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[2] This chapter did not include specific estimates of unmet need for racial/ethnic groups because at the time these estimates were calculated data were not available on the rates at which each racial/ethnic group accessed mental health services in the private sector. These figures were a critical step in the unmet need calculation.

[3] Unless otherwise noted, the data in the following sections on African Americans, American Indians, Asian and Asian Pacific Islanders, and Hispanics/Latinos were taken from *Mental Health:*

African Americans

According to the 2000 U.S. Census, African Americans living in the United States number approximately 34 million and represent 12 percent of the national population. Six percent of these African Americans are foreign born, including 1.5 million from the Caribbean (primarily the Dominican Republic, Haiti, and Jamaica) and from various African nations. African Americans occupy a unique niche in American history in that the legacy of slavery, racism, and discrimination continue to influence their social and economic standing that has significant bearing on their need for mental health services.

Social, Economic, and Educational Status of African Americans

- 62 percent of African American children grow up in single parent families (primarily with their mothers) with increasing gaps and limitations in extended family support.
- Approximately 22 percent of African American families live below the poverty line compared to 10 percent of families overall. African Americans are more likely than Caucasians to live in severe poverty with incomes at or below 50 percent of the poverty threshold.
- African Americans are overrepresented in Southern, rural, impoverished areas with limited access to safety nets providing mental health services.
- African Americans have a disproportionate number of health problems with high mortality and morbidity rates for adults.
- Up to 44 percent of the homeless population is African American with research documenting that the homeless population suffers from mental illness at a higher rate than the general population.
- Nearly 50 percent of all prisoners in state and federal jurisdictions are African American as well as 40 percent of juveniles in legal custody. African Americans are also overrepresented in local jails.
- African American children make up 45 percent of all children in public foster care and more than half of all children waiting to be adopted.
- African Americans are more likely to be victims of serious violent crime than whites with clear links between violence and psychiatric symptoms and illness. Over one quarter of African American youth exposed to violence have symptoms of mental illness.

Mental Health Needs Among African Americans

- Studies suggest that the prevalence rate of mental illness among adults is similar for African Americans and Caucasians. This finding, however, is questioned because of the overrepresentation of African Americans in high-need populations.
- The legitimacy of assessment procedures commonly used to assess mental illness is questionable for African Americans. Further, validity and reliability of common procedures used to assess and treat mental health conditions among African Americans has not been adequately addressed.
- African Americans have higher rates of mental illness than Caucasians due to demographic composition and social position.

Barriers to Service for African Americans

- Disparities in access to mental health services can be partially attributed to financial barriers. African Americans are overrepresented among the working poor, many of whom do not have private insurance and do not qualify for public assistance.
- African Americans often prefer African American mental health providers. Feelings of mistrust, stigma, and perceptions of racism prevent some African Americans from accessing treatment from non-African American providers.

Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General.

- Although African Americans are more likely to seek mental health treatment from primary care providers, many lack a usual source of health care. Mental health care often occurs in emergency rooms and psychiatric hospitals, which undermine delivery of high-quality mental health care.

American Indians

American Indians live in a complex and changing cultural and sociological environment of multiple risk factors linked to a number of behavioral-based health problems. They take a much more holistic approach to health than do most Euro-Americans. Health, including mental health, is considered not only a physical but a spiritual state. A person is considered to be made up of body, mind, and spirit; wellness is the harmony of these three components, illness being caused by disharmony.

Social, Economic, and Educational Status of American Indians

- National studies report that American Indians represent 45 percent of all persons below the poverty level. The 60 percent of American Indians living below poverty level reside in rural reservation areas.
- The prevalence of alcoholism among American Indians has been observed to have reached epidemic proportion and is considered by many to be the number one health problem. From 1980 to 1982, liver disease and cirrhosis death rates for Indians exceeded those for the total population by 420 percent.
- Accidents and violence, often a consequence of alcohol and/or substance abuse, account for 19 percent of Indian deaths, almost three times the national figure. Additionally, at least 80 percent of homicides, suicides, and motor vehicle accidents in the American Indian population are alcohol related (Bobo & Gilchrist, 1983).
- American Indians are twice as likely as whites to be unemployed. In 1999 about 26 percent of American Indians lived in poverty in comparison with 13 percent for the United States as a whole and eight percent for white Americans (U.S. Department of Health and Human Services, 2001).
- Removal from homelands, forced schooling at military-like boarding schools, racism, and overwhelming poverty have wreaked havoc through the traditionally strong, spiritual, and family-centered native culture. Much energy is focused on these problem behaviors associated with American Indian mental health while frequently the situational factors contributing to the psychosocial problems are overlooked (Hodge, 1997).

Mental Health Needs Among American Indians

- A survey associated with the American Indian Child Welfare Act reports 54 percent of the American Indian population has major mental health issues, primarily chronic depression, which affect family functioning and socialization (Hodge, 1997).
- A study of American Indian adults in Northern California found a depressive symptomatology of 42 percent, which is more than twice the U.S. general population rate of 16 percent (Hodge, 1997).
- Suicide is a particularly troubling problem among American Indian youth. Almost half (44.6%) of emotionally distressed adolescents have attempted suicide, compared to 16.9 percent of all youth (Hodge, 1997).

Barriers to Service for American Indians

- The ill-fitting measures of the DSM-IV limit the psychological community's ability to identify and measure problems accurately. Likewise, Eurocentric treatment modalities fail to recognize the strength of native culture and its victory over centuries of tragedy (Hodge, 1997).
- Because of high unemployment rates, many California Indians cannot afford to purchase health care independent of the Indian Health Service. Even those with Medi-Cal coverage find it increasingly difficult to find providers

willing to accept them because of the low reimbursement rates (Hodge, 1997).

- The long history of broken promises and treaties has led to a generalized feeling of mistrust between the white mainstream culture and American Indians. As a result of this lack of trust, American Indians are not willing to utilize the Western medical model or nontraditional methods of healing.
- Many rural American Indians have to travel considerable distances in order to receive health care services. It is not uncommon for American Indians in the northern part of the state to travel hundreds of miles to reach the closest Indian Health Service clinic (Hodge, 1997).
- Because many American Indians do not own reliable automobiles, factors such as distance, road conditions, climate, transportation, and cost of transportation, become major barriers to care (Hodge, 1997).

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders (AAPIs) are the fastest growing racial/ethnic group in the United States. The population grew 95 percent from 3.7 million in 1980 to 7.2 million in 1990. From 1990 to 2000, the number of people identifying as Asian American, or Native Hawaiian or Other Pacific Islander grew by another 44 percent to 10 million for Asian Americans and 350,000 for Native Hawaiians and Other Pacific Islanders. The unmet mental health needs of AAPIs are complex due to the many subgroups within the AAPI community. This section will elaborate on the socio-economic and cultural context for AAPIs and the barriers that lead to their underutilization of mental health services, which is one significant characteristic of this racial/ethnic group.

Social, Economic, Educational Status of Asian Americans and Pacific Islanders

- A stereotype that AAPIs are a model minority persists when, in fact, poverty, acculturation, stress, juvenile justice, and substance abuse are problems among these communities.
- AAPIs are heavily represented among refugees and new immigrants.
- AAPIs represent over 46 different groups that speak over 100 languages.
- Overall, about 21 percent of AAPIs lack health insurance compared to 16 percent of all Americans.

Mental Health Needs Among Asian Americans and Pacific Islanders

- Less is known about the rates of psychiatric disorders for AAPIs using DSM categories than is known for most other major ethnic groups. Data that are available indicate that AAPIs are not "mentally healthier" than other populations.
- While depression, anxiety, and substance use/abuse have been documented in the AAPI community, expression of distress and views of normality and abnormality may very well be different in AAPI communities.
- Very little is known about the mental health needs of the diverse groups of AAPI adolescents, children and families.
- Little information is available on the prevalence of psychiatric disorders among older Asian Americans.
- AAPIs have the lowest rates of utilization of mental health services among ethnic populations. Among those who do utilize services, severity of disturbance is high. Individuals delay services until need is high and the resources of the family or community are greatly stressed.

Barriers to Service for Asian Americans and Pacific Islanders

- AAPI cultures often focus on groups or the family, rather than individuality. To seek services outside the home is not highly supported.
- Optimal interventions for AAPIs are limited by the striking lack of knowledge of rate and distribution of disorders and factors associated with health and illness.

- Low utilization of services is attributable to stigma and shame; lack of financial resources, including health insurance; different conceptions of health and treatment and cultural inappropriateness or "lack of fit" of services. AAPIs may use alternative resources or healing practices.
- Lack of providers who speak the same language or dialects as mental health clients is significant. Nearly one out of two AAPIs will have difficulty accessing mental health services because they do not speak English or cannot find services that meet their linguistic needs.

Hispanic/Latino Americans

The Hispanic/Latino American population is characterized by its rapid growth. The number is expected to increase to 97 million by 2050. Historical and socio-cultural factors suggest that, as a group, Hispanics/Latinos are in great need of mental health services.

Social, Economic, and Educational Status of Hispanic/Latino Americans

- Approximately two-thirds of Hispanic/Latino family households included children under the age of 18 in 1999.
- Overall, only 56 percent of Hispanics/Latinos 25 years of age and over have graduated from high school.
- The economic status of Hispanics/Latinos parallels their educational status. Poverty rates for this group are higher than any other group.
- Of the people who are incarcerated, 9 percent are Hispanic/Latino Americans as compared to 3 percent of non-Hispanic/Latino white Americans. Hispanic/Latino men are nearly four times as likely as white men to be imprisoned at some point during their lifetime.

Mental Health Needs Among Hispanic/Latino Americans

- Hispanics/Latinos suffer from more health disorders than white Americans.
- Mexican Americans who were born in the United States are at higher risk of mental disorders.
- Studies have found that Hispanic/Latino youth experience proportionately more anxiety-related and delinquency problem behaviors, depression, and drug use than do non-Hispanic/Latino white youth.
- Regarding older Hispanic/Latino Americans, one study found over 26 percent of its sample were depressed, but depression was related to physical health.
- High school Hispanic/Latino adolescents reported more suicidal ideation and attempts proportionally than non-Hispanic/Latino whites and African Americans.
- Rates of substance abuse are higher among U.S. born Mexican Americans as compared with Mexican born immigrants.

Barriers to Services for Hispanic/Latino Americans

- The system of mental health services currently in place fails to provide for the vast majority of Hispanic/Latino Americans in need of care.
- As many as 40 percent Hispanic/Latino Americans report having limited English proficiency. With few mental health providers identifying themselves as Spanish speaking, access to bilingual, bicultural services is limited.
- Poor penetration rates, access barriers, and poor quality of services have contributed to the underutilization of mental health services by Hispanic/Latino Americans.

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