Scope of the problem

The number of people displaced from their home countries due to war, armed conflict, political violence, and related threats are growing. If current trends continue, one in 100 persons will be a refugee in the near future.\(^1\)

Unfortunately, most refugees, asylum seekers, unaccompanied minors, and other survivors of forced displacement will not receive needed mental health care due to scarcity of services and stigma against mental health care. Worldwide, over 65 million persons are currently displaced by war, armed conflict, or persecution, the majority of whom are located in low- and lower-middle income countries. Globally, half of the refugees live in unstable and insecure situations. There are 3.1 million asylum seekers and more than 25 million refugees, half of whom are under 18 years old. As of early 2018, almost 31 million children worldwide have been displaced by violence and conflict.\(^2\)

**Refugees** are defined as someone who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country.\(^3\)” An **asylum seeker** has also experienced persecution but has crossed borders to seek sanctuary. Refugees and asylum seekers differ only in where they are located when they make a request for protection.\(^4\)

The experience of **forcibly displaced youth** is varied – some have endured chronic pervasive exposure to interpersonal and community violence, the uncertainty of the future, personal
or family persecution, violent loss of loved ones, and an insecure environment. Others have experienced a shorter exposure to high violence such as active war. Some youth come from areas of armed conflict and war with their conscription into the armed forces as “child soldiers”, some arrive without parents or caretakers as unaccompanied and separated minors, and other youths flee with intact families.

The migration experience for youth forcibly displaced from their homes to the U.S. is also varied. Refugee and asylum-seeking youth may travel by plane or train without exposure to violence or danger if they have resources. Others have long migration journeys across multiple countries, exposure to physical and sexual assault, hiding, and lack of basic needs such as food, clean water, and the ability to maintain personal hygiene.

Oftentimes, forcibly displaced youth must abruptly leave all belongings except only the most necessary and quickly say goodbye to loved ones who may be unable to join. They do not necessarily want to leave the home environment and culture that raised them. Therefore, these youth lose not only material resources like housing, education, access to food and water, and security, but also social relationships and cultural supports.

Refugees do not choose which country they would like to live in. The United Nations High Commissioner for Refugees makes recommendations to select countries. There are eight U.S. federal agencies, six security database biometric security checks, three in-person interviews with the Department of Homeland Security, and medical checks that are involved in the thorough screening of refugees which can take between 1-2 years.

Historically, the U.S. resettlement program was one of the largest in the world since the 1970s, offering resettlement to the most vulnerable: at-risk women and children, female-headed households, elderly, and survivors of violence and torture, and those with acute medical needs. In the past decade, there were an average 75,000 refugees admitted into the U.S., but that number has gone down significantly recently. Only 22,491 refugees were admitted in the fiscal year 2018- the lowest in more than 40 years.

Due to a family separation policy, formally enacted in April 2018 that called for every illegal entry case across the border to be prosecuted, children (who could not be prosecuted) were separated from their parents. Between October 2017 and April 2018, an estimated 700 families were separated. In June 2018, an executive order was signed to end family separations at the border.

Mental health of survivors of forced displacement resettled in high-income countries

About one out of three asylum seekers and refugees experience high rates of depression, anxiety, and post-traumatic stress disorders (PTSD).

However, systematic reviews show that prevalence estimates of mental health disorders
for this population vary widely from 20% to 80% specifically.

- 4 to 40% for anxiety,
- 5 to 44% for depression
- 9 to 36% in PTSD

While most refugees and asylum seekers with PTSD and depression show a reduction over time, particularly if there are low resettlement stressors others may experience years of PTSD.

Early mental health care should, therefore, be a priority for resettled youth, as post-migration stressors such as prolonged detention, insecure immigration status, and limitations on work and education, can worsen mental health. When individuals and families seek safety by leaving their homes, cultures, and communities due to the threats of violence and persecution, emotional distress can be heightened.

Once forcibly displaced persons reach the U.S., they often face multiple postmigration stressors of poverty, insecure housing, unemployment, multiple moves with changes in neighborhoods, isolation, stressful legal issues, poor access to services, and general disadvantage in the host country, which can all adversely impact mental health.

**Systems of care for the mental health of refugees and asylum seekers**

Providing mental health care for refugees and asylum seekers should be done in partnership with the other social, cultural, and family supports around the individual. Such an approach highlights the influence of environment on mental well-being. Clinicians can serve as advocates by linking refugees with psychosocial support to assist with housing, legal aid, access to health care, education, and employment.

Refugees and asylum seekers may be resistant to seeking mental health care due to beliefs that diagnosis will interfere with jobs and housing, that there is no treatment, cultural values surrounding silence/disclosure, differing beliefs surrounding etiology/manifestation of emotional health, and lack of incorporation of these beliefs into care.

Common structural barriers to care are lack of education about the mental health system and resources, health insurance issues, transportation, language proficiency, or provider refusal to see refugees.

Refugees may have barriers to seeking care, but health systems may also have barriers to referring people for services, as only about 3% of refugees are referred to mental health services following screening.

**Strengths and protective factors common to refugees and asylum-seekers**

Despite the high rate of exposure to traumatic events among the refugee population, many do not have chronic psychiatric impairment. Clinicians should, therefore, make the distinction between normal responses to the abnormal situations of war, protracted violence, and other traumatic experiences that many conflict-affected persons face, and the more severe and less common psychiatric response.

Mental health providers can highlight the resilient processes that conflict-affected people can draw upon. Commonly thought of as the ability to adapt in the face of adversity, resilience is time- and context-dependent, and a process that can be developed across individual, family, and community levels.
Clinicians should be mindful of the on-going stressors that one may face, of ambiguous or traumatic loss of loved ones and separation from culture and supports, on-top of the host environment that may foster discrimination and marginalization. It is important to highlight the socio-ecological supportive factors that assist in re-building a new normal.

Helping patients engage with family strengthening and building social networks can develop a sense of connectedness to minimize isolation and foster increased resilience and improved mental health. Providers can assist in making the environment less difficult by conceptualizing mental health, social environment, and individuals and families as interconnected, to decrease risk factors for adverse mental health and promote well-being.

**This resource was prepared by the APA Division of Diversity and Health Equity. It was authored by Suzan Song, MD, MPH, Ph.D. and Sara Teichholz, M.D., and reviewed by Steven M. Weine, M.D.**

**References:**

7. USA for UNHCR Fact Sheet website available at: https://www.unrefugees.org/refugee-facts/usa/
Gender Differences in Mental Disorders

Recent research has identified disparities between women and men in regard to risk, prevalence, presentation, course, and treatment of mental disorders.

Rates of Mental Health Conditions – Each year, 1 in 5 women in the United States has a mental health problem such as depression, post-traumatic stress disorder (PTSD), or an eating disorder.5

Research – Although research shows that women and men have similar rates of mental health problems, the types of mental conditions may differ.6

Depression – The most common mental health problem in women is depression. Twice as many women experience depression in their lifetime than men. Approximately 1 in 9 women 18 and older have had at least one major depressive episode in the past year.7

PTSD – Compared with men, women are twice as likely to experience PTSD. Women are more likely to have hypervigilance, feel depressed, and have trouble feeling emotions; men are more likely to feel angry and have problems with alcohol or drugs.9

Anxiety – Women are twice as likely as men to experience generalized anxiety disorder or panic disorder.9

Suicide – Women attempt suicide more often than men; however, men are four times more likely to die by suicide.10

Eating Disorders – Approximately 85%-95% of women and men have differences in the rates of eating disorders during their lives.

Rates of Mental Health Disorders in Women and Men

Source: National Comorbidity Survey Replication, 2005

people with anorexia nervosa or bulimia and 65% of people with binge eating disorder are women.\textsuperscript{11}

**Schizophrenia** - Rates of schizophrenia are similar among men and women. Schizophrenia generally appears in women in their late twenties or early thirties; and in men, from late teens to early twenties.\textsuperscript{12}

**Alcohol use** - Women are less likely to experience alcohol use disorder than men.\textsuperscript{13}

### Risk Factors for Mental Health Problems in Women

Women disproportionately experience the following risk factors for common mental disorders than men.

- Women earn less than men. Women who are full time workers earn about one-fourth less than male counterparts in a given year.\textsuperscript{1}

- The poverty rate for women aged 18 to 64 is 14.2% compared with 10.5% for men. For women aged 65 and older the poverty rate is 10.3%, while the poverty rate for men aged 65 and older is 7.0%.\textsuperscript{1}

- Victims of violence: About 1 in 3 women have experienced sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime.\textsuperscript{2}

- An estimated 65% of caregivers are women. Female caregivers may spend as much as 50% more time providing care than male caregivers.\textsuperscript{3}

### Gender Differences in Seeking/Receiving Mental Health Services

According to a study from the World Health Organization, there are differences in the way women and men seek and use mental health services. There are also differences in the treatment provided.

- Women are more likely to be prescribed psychotropic medications than men.

- Women are more likely to seek help from and disclose mental health problems to their primary health care physician; men are more likely to seek out a mental health specialist.

- Women are less likely than men to disclose problems with alcohol use to their health care provider.

- Women are reluctant to disclose a history of violent victimization unless physicians ask about it directly.

- Women are more likely to be prescribed psychotropic medications than men.

- Physicians are more likely to diagnose depression in women compared with men, even when both genders have identical symptoms or similar scores on standardized measures of depression.

### Barriers to Accessing Mental Health Care Services Among Women

Key barriers to mental health treatment for women:

- Economic barriers – lack of insurance/cost (including premiums and copays)

- Lack of awareness about mental health issues, treatment options, and available services

- Stigma associated with mental illness

- Lack of time/related support (time off work, child care, transportation)

- Lack of appropriate intervention strategies including integration of mental health and primary health care services

To learn about best practices for treating diverse populations and to get answers to your questions by leading psychiatrists, please visit APA’s Cultural Competency webpage at [https://www.psychiatry.org/psychiatrists/cultural-competency](https://www.psychiatry.org/psychiatrists/cultural-competency).
Footnotes

1 SAMHSA. 2014. “Past Year Mental Disorders among Adults in the United States: Results from the 2008-2012 Mental Health Surveillance Study.” CBHSQ DATA Review. samhsa.gov/data/sites/default/files/NSDUH-DR-N2MentalDis-2014-1/Web/NSDUH-DR-N2MentalDis-2014.htm


This educational resource was prepared by the Division of Diversity and Health Equity. Updated and reviewed by Misty Richards, M.D., Maureen Sayres Van Niel, M.D., and the Council on Minority Mental Health and Health Disparities.
Mental Health Facts on Questioning/Queer Populations

Introduction

When applied in an affirming manner, queer is often used as an umbrella term to describe sexual orientation or gender identity that does not conform to dominant societal norms (e.g., straight/heterosexual and cisgender). Additionally, people who identify as queer have a sexual orientation that does not match conventional labels like gay, lesbian, or bisexual.

Queer may include identities such as

- **Questioning**: the process of a person determining their sexual orientation and/or gender identity; questioning the default presumption of heterosexuality in U.S. society (i.e. heterosexism).
- **Asexual**: A term used by people who do not experience sexual attraction. Aromantic describes people who don’t experience romantic attraction.
- **Lesbian, Gay, Bisexual, Transgender (LGBT)**: See APA Factsheet on LGBTQ
- **Pansexual**: Identity label used by individuals who are attracted to multiple or many genders. Some pansexual people may consider themselves part of the bisexual community.
- **Genderqueer**: An umbrella term used by some individuals to describe gender identity that does not conform to the male-female gender binary.

Why are the terms queer/questioning important?*

The terms queer/questioning are important because they encompass a larger number of individuals who identify as having same-sex attraction and behaviors versus self-identifying as LGB. This data underscores the importance of assessing specifics (i.e.: attraction and behavior with all individuals) rather than relying on identified labels to tell the whole story. If someone uses a word like queer to describe themselves, ask what that label means to them.

*Most data collecting sources offer default options of lesbian, gay, bisexual, transgender, without space to write in other options. Therefore, what follows are general trends that can be understood as “queer and questioning” data from surveys that query about same-sex attraction, same-sex behaviors, and those that are sexual minorities.
Thinking Beyond the Binary to Understand Queer/Questioning

Binary typically refers to something that is divided in two. When used in relation to sexual orientation, it splits the population into homosexual or heterosexual. People's identities may not always fit into the categories that we have created to describe sexual orientation. Because of this, they may feel confused or believe their identity isn't valid.

The identity labels presented previously were developed by such communities to more accurately describe their sexual orientation and gender identity. It is important to remember that sexual orientation is on a spectrum as feelings of attraction and sexual behavior may be complicated and don't fit into traditional categories. They may also change over time.

Below are some examples:

**JASIA** has always considered herself to be straight, but now she's wondering if that's really true. She has always thought about dating men only, but now she thinks she might have a crush on her coworker, Liza. Jasia is currently questioning her sexual orientation.

**JUDITH** is mainly attracted to men, but every so often she sees a woman that catches her eye. So far Judith has only had relationships with men, but she's open to having a relationship with a woman if the right one came around. Because of this, Judith identifies as queer and is approximately a 2 on the Kinsey Scale.

**CAMERON** is attracted to all genders, but he finds that he has a slight preference for men. Because of this, Cameron feels like the term bisexual doesn't truly reflect how he feels. Cameron instead identifies as queer and is approximately a 4 on the Kinsey Scale.

**LANEY** is only attracted to women. She chooses to identify as both a lesbian and a queer woman. Even though she fits in with a more traditional label, Laney feels like the political connotations that come along with identifying as queer better describe her. Laney is approximately as a 6 on the Kinsey Scale.

**TEDDY** is not sexually attracted to any gender. He is currently in a committed relationship with his partner, Bryce. Teddy identifies as both genderqueer and asexual. Because of this, Teddy considers himself part of the queer community and an X on the Kinsey Scale.

### General Trends in Mental Health Care

Like other minority groups, including the LGBT community, questioning and queer people are often misunderstood, overlooked, and underrepresented in the health care system and societal institutions (e.g., media). Although the Diagnostic and Statistical Manual of Mental Disorders (DSM) established that homosexuality was NOT a mental disorder in 1973, enormous stigma continues to surround those who are not heterosexual or cisgender. This can manifest in worsening mental health as a result of prejudice, bias, and discrimination within society:

#### Mental Health Trends Amongst Individuals with Same-Gender Attraction

Data that specifically assesses the mental health status of questioning/queer individuals is limited. Studies show that those who identify as bisexual...
tend not to disclose, which is likely the case for questioning/queer. Therefore, data for assessing mental health of queer/questioning is currently included in the overall data of LGBQ until further studies are done on this population.

• LGBQ are more than twice as likely as heterosexual men and women to have a mental health disorder in their lifetime.\(^5\)

• Individuals with same-gender attractions are 2.5 times more likely to experience depression, anxiety, and substance misuse compared with heterosexual individuals.\(^5\)

  o Women with same-gender attractions are more than twice as likely to engage in heavy (alcohol) drinking in the past month than heterosexual women (8.0% vs. 4.4%). Men with same-gender attraction are less likely than heterosexual men (8.6% vs 9.9%) to engage in heavy drinking in the past month.\(^5\)

  o The rate of suicide attempts is four times greater for lesbian, gay, and bisexual youth and two times greater for questioning youth than that of heterosexual youth.\(^5\)

• LGBQ older adults face a number of unique challenges, including the combination of anti-LGBTQ stigma and ageism. Approximately 31% of LGBQ older adults report depressive symptoms; 39% report serious thoughts of taking their own lives.\(^5\)

**Trends in Healthcare Services Access and Utilization**

Questioning/Queer people are likely to experience sexual orientation identity and/or gender identity-related discrimination in healthcare settings. They also have a limited access to and use of health services. Such experiences lead to adverse health outcomes and delay in receiving care.\(^6\)

Data shows that adolescents questioning their sexual orientation identity are at higher risk for negative health outcomes compared to LGB and heterosexual youth. The possible reasons for these negative outcomes may include internalized homonegativity and lack of providers with expertise in Questioning/Queer mental health.\(^6\)

Questioning/Queer people are more likely to experience the denial of services or unequal treatment compared with gay/lesbian and bisexual individuals. They are also less likely to be insured than heterosexual and bisexual individuals.\(^6\)

Research shows that when same-sex oriented individuals disclose their sexuality to health care providers, it tends to have a positive impact on health and greater satisfaction with the providers and more routine follow up of preventive screenings. However, the outcomes depend on how the healthcare provider responds.\(^4\)

**Commonly Asked Questions**

► **Is queer a slur?**

While queer has historically been used as a slur, it has recently been reclaimed by the queer community in an effort to focus less on labels and more on breaking binaries. However, some people, especially older members of the queer community, still find the word offensive, so it is important to establish whether or not it is appropriate to use this label. A helpful rule for using the word is to say someone "identifies as queer," instead of saying that a person is "queer."

► **As a provider, should I ask every patient if they are queer, questioning, or another part of the spectrum?**

If you are conducting a patient interview that includes a sexual history, then yes, you should not only be inquiring about sexual practices but also sexual attraction. It should be standard practice to obtain a sexual history on every new patient, despite commonly held assumptions about population groups that we may not assume are sexually active (i.e.: the elderly). Conflict related to sexual orientation, like conflict related to other personal problems, can cause stress that exacerbates symptoms. Also, while we have introduced terms to describe attraction/behavior, be careful not to force a label on a patient.

► **Is there a certain age when people question their sexual orientation and/or gender identity?**

No. People can question their sexual orientation and/or gender identity at any point in their life. It is essential to validate someone’s identity, no matter their age or how they previously identified.
What if my patient is not currently sexually active?

Do I still have to ask about sexual attraction and behaviors? Yes. Your patient may not currently be sexually active because they are questioning their sexuality and have not discussed it with anyone else. Also, routinely asking about sexual orientation is a good practice to establish to reinforce normativity and reduce stigma surrounding sexual minorities.

This is a lot of information to remember. What if I say something wrong and offend someone?

Like most technical information, initial exposure to concepts in the field of medicine can be difficult to remember or to grasp. However, as health care professionals, it is our responsibility to stay updated to common standards through continuing medical education, self-directed learning, or other educational means. And like most instances when a mistake is made, it is imperative to apologize or admit to mistakes to ensure a trustworthy therapeutic alliance.

Tips to Talk to Patients

Below is sample language to use when asking patients about their sexual orientation with respect to the spectrum. The wording of the questions was adapted from the APA’s Cultural Formulation Interview (CFI), outlined in the DSM-5. The CFI is an evidence-based questionnaire that can assist in making person-centered assessments in clinical encounters with all patients and all clinicians, not just in situations of obvious cultural difference between clinicians and patients.

Starting the conversation:

“I ask all my patients these questions…”

“I see that you are married to a woman, to make sure I’ve covered all my bases just want to know if you have always been sexually attracted to women or had any sexual experiences with anyone who does not identify as female?”

Asking about sexual orientation:

• “How do you define/think about your sexual orientation?”
• “Are you currently in a relationship?”
• “If you were to be sexually active, or were in the past, what kinds of people are you attracted to—men, women, gender nonconforming individuals?”
• “Is there a specific term or label that you use to describe your sexual identity?”

Asking about symptoms & sex:

• “How does your sexuality lead to extra stress in your daily life?”

• “How does your sexuality fit in with the rest of your identity? “What kinds of problems does this pose, if it does?”
• “How do you deal with stress caused by your sex life? How is it working?”

Tips for Success

• Make sure to ask about how those in the patient’s support system think about questioning/queer and sexuality in general. You might be the first and/or only person to whom the patient discloses this information, which can be isolating.
• Curate an inclusive office setting: offer pamphlets about sexual orientation, intake forms that list broad categories of gender & sexual orientation, ensure office staff is respectful.
  o Calling patient by preferred name
  o Appropriate confidential calls to get a patient’s attention or greeting in the waiting room around others
  o Reinforce non-prejudicial office talk amongst staff
• Assess timing and developmental stage at which non-straight attraction or behaviors were asserted
  o Those with longer lag to asserting same-sex sexuality tend to have higher rates of depression/substance abuse issues
• When in doubt, seek training. If you don’t know something, best to ask, openly and acknowledge uncertainty.

This resource was prepared by APA Division of Diversity and Health Equity. It was authored by Dr. Kali Cyrus and Catherine Morrison and reviewed by Drs. Eric Yarbrough, Andrew Tompkins, Jeremy Kidd and Daena Petersen.
References:

3. Gates, Gary J. (April 2011). “How many people are lesbian, gay, bisexual, and transgender?”. Williams Institute, University of California School of Law.
Demographics

• Based on estimates by the Pew Research Center, there are about 3.45 million Muslims living in the U.S., comprising about 1.1% of the total U.S. population. Other sources report a range of 3.4 to 7 million Muslims in America. (Based on independent demographic research, US Census does not formally ask religious affiliation, therefore the range is so broad.)

• By 2050, the U.S. Muslim population is projected to be more than 8 million, surpassing Judaism as the second most common faith in the U.S.

• 42% of Muslim Americans are U.S. born. 58% are immigrants, more than half of whom moved to U.S. in the last two decades.

• 18% of Muslim American adults are second-generation, and 24% are third-generation or later.

• Muslim Americans are the youngest faith group in the U.S., with one-third under 30 years old.

• Muslim immigrants come from 75 different countries around the world; no single country or region accounts for a majority of Muslim immigrants, making it one of the most diverse religious community in U.S.

• 85% of Muslim Americans say their faith identity is a source of happiness in their lives, only surpassed by white Evangelicals (94%).

• A majority of Muslims (64%) support a pluralistic approach to their faith, maintaining that there are multiple true ways to interpret Islam.

Population Distribution of Muslim Americans in the United States

• Muslim Americans can be found throughout the United States, and often reside in larger metropolitan areas, particularly immigrants.
Social Determinants of Mental Health

- Muslim women (73%) are more likely than Muslim men (57%) to pursue higher education beyond high school; they are also more likely to report being in the middle class.\(^4\)
- Muslim Americans, especially Black and Arab Muslims, are more likely than any other faith group to report low (<$30,000) household income despite similar educational attainment.\(^4\)
- Immigrant Muslim Americans tend to have better household incomes and levels of education compared with the general U.S. public, while U.S. born Muslim Americans tend to have lower household incomes and levels of education compared with the general U.S. public.\(^3\) (Table 1)

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Muslim Americans</th>
<th>U.S. General Public</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Immigrants</td>
<td>U.S. Born</td>
</tr>
<tr>
<td>&lt;$30,000</td>
<td>37%</td>
<td>45%</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>29%</td>
<td>18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Immigrants</th>
<th>U.S. Born</th>
<th>Immigrants</th>
<th>U.S. Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School</td>
<td>10%</td>
<td>7%</td>
<td>25%</td>
<td>9%</td>
</tr>
<tr>
<td>College graduate and higher</td>
<td>38%</td>
<td>21%</td>
<td>31%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Mental Health Status and Disparities

- Data on community prevalence of psychiatric disorders among Muslim Americans is scarce. There is, however, some data available on prevalence among clinical samples seeking treatment.\(^7\) (Table 2)
- Existing data show high rates of adjustment disorder experienced by Muslim Americans seeking mental health treatment, which may be suggestive of the challenges of acculturation and adjustment, as well as discrimination and marginalization in society.\(^7\)

<table>
<thead>
<tr>
<th>Diagnosis on Intake</th>
<th>Muslim Americans at Hamdard Center for Health and Human Services, Chicago (N= 875)</th>
<th>Muslims adolescents from various social service agencies in Illinois, Michigan, Missouri, Virginia, and Kentucky (N=712)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment Disorder</td>
<td>43%</td>
<td>19%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>9%</td>
<td>15%</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>14%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder</td>
<td>10%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
### Table 2. Prevalence of psychiatric disorders in clinical samples of Muslim Americans (Data from Basit and Hamid, 2010)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Clinical Sample 1</th>
<th>Clinical Sample 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorders</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>ADHD</td>
<td>Not reported</td>
<td>16%</td>
</tr>
<tr>
<td>Impulse Control Disorder</td>
<td>Not reported</td>
<td>5%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>Not reported</td>
<td>2%</td>
</tr>
<tr>
<td>Somatoform Disorder</td>
<td>Not reported</td>
<td>1%</td>
</tr>
<tr>
<td>Other issues (including trauma, violence, cultural conflicts)</td>
<td>Not reported</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Perceptions of Mental Health among Muslim Americans

- Muslim Americans generally adhere primarily to the dominant Western biomedical model of mental illness.  
- Mental illness also can be perceived as being
  - due to the will of God, as a test or a punishment
  - an opportunity to remedy disconnection from God
  - possession by evil spirits
- Reassuringly, religious explanations of mental illness are generally not seen to be in conflict with biological or environmental causes.
- Some may consider disclosure of mental illness to be “shameful” due to social stigma. Women may have fears related to their marital prospects within the Muslim community if psychiatric diagnoses are disclosed.

### Islamic Religiosity and Mental Health Benefits

- Islam promotes healthy behaviors:
  - Emphasis on personal hygiene
  - Injunctions against alcohol and substance use
  - Prohibition of sexual promiscuity
  - Recommendation to breastfeed
  - Strong sense of community
  - Recommendation to engage in daily reflective practices
- Religiosity is predictive of better family functioning and less depression.
- Observing daily prayers is associated with reduced depression.

### Islamophobia, discrimination and mental health

- 60% of Muslim Americans reported some level of religious discrimination in 2016, surpassing all other religious groups. Younger Muslims, women and Arabs are most likely to experience prejudice based on their religion.
- Nearly one-third of Muslim Americans perceived discrimination in health care settings; being excluded or ignored was the most frequently conveyed type of discrimination.
- Religious discrimination against Muslims is associated with depression, anxiety, subclinical paranoia, and alcohol use.
Recent travel and immigration restrictions directed primarily at Muslim countries by the U.S. government have led to traumatizing experiences for many Muslim Americans. In particular, the harsh handling and long detainments by U.S. Customs and Border Protection can be retraumatizing to those already vulnerable. 

Clinicians and mental health providers have a crucial role in addressing societally connected mental health challenges arising from Islamophobia. 

There is a strong need for research and applied programs that specifically focus on the well-being of Muslim American communities, especially amidst the largest spike in anti-Muslim hate crimes that corresponded with the 2016 Presidential elections. 

Involvement in community interventions can be utilized by providers to counter Islamophobia and encourage Muslim Americans to seek professional mental health care. 

<table>
<thead>
<tr>
<th>Percentage who say</th>
<th>Immigrant Muslims in US</th>
<th>U.S. Born Muslims</th>
</tr>
</thead>
<tbody>
<tr>
<td>They experienced at least one of the incidents below because they are Muslim</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Someone acted suspicious around them</td>
<td>20%</td>
<td>47%</td>
</tr>
<tr>
<td>They were called offensive names</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>They've been physically threatened or attacked</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Airport security singled them out</td>
<td>17%</td>
<td>19%</td>
</tr>
<tr>
<td>Law enforcement officers have singled them out</td>
<td>4%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Table 3. Nature and prevalence of discrimination experienced by Muslim Americans (Pew Research Center, 2018)

**Muslim Women**

- Women experience more fear for their safety than Muslim men, and suffer emotional trauma at higher rates than male counterparts.
- Muslim women are the most likely of any faith to wear visible symbol of faith identity, such as the hijab; the majority wear it to express piety, Muslim identity or modesty, only 1% wear it because someone else required it.
- Wearing the hijab can make Muslim women a particular target for social discrimination; however, Muslim women are no more likely than men to alter their appearance to be less identified as Muslim.
- Women in Muslim immigrant populations may have difficulty leaving abusive relationships due to a sense of duty and fear of social ostracization, as well as concerns over financial independence and immigration status.
- Muslim immigrant women more afraid to call the police for domestic violence over fear of community reaction, wanting to protect their partners and children.
- Female genital mutilation (FGM) is not an Islamic practice. Although it is legally prohibited in U.S., it has been practiced among certain African refugee populations, and psychiatrists may come across psychological consequences of FGM.

**Muslim Children and Young Adults**

- Younger Muslims value religious identity as much as older Muslims. They are more likely than peers in other faiths to attend services and say religion is important to their identity.
- Muslim youth face greater challenges in integration with their social peers, and are vulnerable to Islamophobia and religious discrimination.
- Muslim school-age children are four times as
likely to be bullied as the general public; of these incidents, one quarter involve bullying by a teacher or other school official.\(^4\)

- 50% of Muslim youths in one study experienced psychological bullying, while 21% experienced cyber-bullying and 10% physical bullying; 17% of girls wearing the hijab were bullied because of this.\(^23\)
- Among Muslim adolescents and especially girls, acculturative stress leads to more withdrawal, anxiety and depression, regardless of first or second-generation.\(^24\)

**Faith Leaders and Mental Health**

- Imams (Muslim faith leaders) have an integral role in community mental health; Muslim Americans may be more willing to seek help from religious leaders than formal mental health services.\(^9\)
- Up to 95% of imams spend some amount of time in counseling activities addressing issues beyond spiritual concerns, including family problems, relationship or marital concerns, mood and anxiety.\(^26\)
- Imams are less likely than other clergy to have formal counseling training.\(^26\)
- Most imams have noted an increase in need for counseling after 9/11 around issues of religious discrimination and Islamophobia.\(^26\)
- Muslims are more likely to report domestic violence to faith leaders than other faith groups.\(^4\)

**Cultural and Faith Based Considerations in treating Muslim Americans**

- The Islamic tradition places strong emphasis on mental health, and its perspective transcends mind-body dualism to integrate behavioral and physical health.\(^27\)
- A lack of understanding or knowledge about the religious beliefs, customs, or rituals of Muslim patients by non-Muslim providers may be an impediment in establishing a therapeutic relationship.\(^28\)
- Most common healthcare accommodation requested is for a same-sex provider, often driven by religious and cultural norms around separation of genders.\(^29\)
- During inpatient services, Muslim Americans may ask for a neutral space (free of human images) for daily prayer, facing east (towards Mecca).\(^29\)
- Many may seek halal dietary options, similar but distinct from Jewish kosher; Muslim Americans may avoid porcine-derived heparin and insulin because pork is considered “impure.”\(^29\)
- During Ramadan daytime fasting, patients- even sick and pregnant ones- may not want to take medications or injections during the day. They may benefit from risk/benefit discussions around fasting.\(^29\)
- Many Muslims see prayer and reading of the Quran as having health benefits and may utilize these as a source of healing complementary to medical interventions.\(^2\)
- Humoral theories relating medical and psychiatric conditions to hot-cold, dry-moist oppositions in diet are observed in some Muslim cultures. Based on such thinking, foods can be classified as ‘hot’, ‘cold’, ‘dry’, or ‘moist’ with corresponding effects on temperament and behavior. For instance, cold foods (such as cucumber and lettuce) may lead to sluggishness in behavior, and dry foods (such as lentils and dried meat) may lead to loss of appetite and depression, if consumed in excess.\(^9,21,32\)
- Certain Muslim communities, such as Pakistani and Egyptian, have high rates of consanguineous marriage which can increase risk of developmental and psychiatric disorders.\(^30,31\)
- Expressing emotional distress in somatic terms often occurs in Muslim cultures, particularly from the Middle East and North Africa.\(^9\)
References:


LGBTQ Population

Population estimates of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) people vary widely, in part because of differences in how this data is collected. Surveys may ask about different elements of sexuality (e.g., sexual attraction, sexual behavior, self-identification, or some combination). Often, these domains are not perfectly correlated (e.g., a heterosexual-identified man who has sex with both men and women, but who is primarily attracted to women). Measuring only one or two domains can yield different population estimates.

Sexual Identity - Approximately 9 million US adults (3.8%) identify themselves as lesbian or gay (1.7%), bisexual (1.8%), or transgender (0.3%).

Sexual Behavior - Approximately 19 million Americans (8.2%) report engaging in same-sex sexual behavior.

Sexual Attraction - Nearly 25.6 million Americans (11%) acknowledge at least some same-sex sexual attraction.1,2

Transgender is a term that refers to people whose gender identity (or gender expression) differs in some way from the sex they were assigned at

---

**Percentage of LGBTQ Population by State**

![Map showing percentage of LGBTQ population by state](image.png)

Source: Gates & Newport, 2013
Transgender individuals may identify in myriad ways. Some people identify as another gender (e.g., man or woman), while others adopt a non-binary identity (e.g., genderqueer) or no gender at all. Some transgender people seek medical or surgical treatments to help with gender transition while others do not. One recent study estimated that there are nearly 1 million transgender people in the U.S.³

Population estimates of LGBTQ people also appear to vary geographically, ranging from an average of 2% in South Dakota to 5.3% in Hawaii and 8.3% in the District of Columbia.⁴

### Mental Health Status and Disparities

- LGBTQ individuals are more than twice as likely as heterosexual men and women to have a mental health disorder in their lifetime.⁵
- LGBTQ individuals are 2.5 times more likely to experience depression, anxiety, and substance misuse compared with heterosexual individuals.⁶
- Women who identify as lesbian/bisexual are more than twice as likely to engage in heavy (alcohol) drinking in the past month than heterosexual women (8.0% vs. 4.4%). Gay/bisexual men were less likely than heterosexual men (8.6% vs 9.9%) to engage in heavy drinking in the past month.⁷
- Transgender individuals who identify as African American/black, Hispanic/Latino, American Indian/Alaska Native, or Multiracial/Mixed Race are at increased risk of suicide attempts than white transgender individuals.⁸
- LGBTQ individuals have higher rates of mental health service use than their heterosexual counterparts.⁹

### Suicide Rates by Sexual Orientation

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Considered Attempting Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>2.3%</td>
</tr>
<tr>
<td>Gay or Lesbian</td>
<td>4.4%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>7.4%</td>
</tr>
<tr>
<td>Transgender</td>
<td>30.8%</td>
</tr>
</tbody>
</table>

The rate of suicide attempts is four times greater for lesbian, gay, and bisexual youth and two times greater for questioning youth than that of heterosexual youth. ¹⁰

LGBTQ older adults face a number of unique challenges, including the combination of anti-LGBTQ stigma and ageism. Approximately 31% of LGBTQ older adults report depressive symptoms; 39% report serious thoughts of taking their own lives. ¹¹

**Stigma & Discrimination**

Health disparities among LGBTQ people are linked to stigma and discrimination.⁶ For example:

- Many LGBTQ people have reported experiencing stigma and discrimination when accessing health services, leading some individuals to delay necessary health care or forego it altogether. ¹²

- LGBTQ individuals may have less social support than heterosexual individuals, particularly if they live in a region without a large LGBTQ population or if they have experienced rejection by their family of origin. Bisexual people may feel particularly isolated, experiencing stigma both in society at-large and within the LGBTQ community. ¹³

- Transgender individuals have higher rates of poverty and unemployment than non-transgender individuals.¹⁴ This is exacerbated by a lack of federal employment non-discrimination protections for LGBTQ individuals.

- LGBTQ individuals are more likely to be victims of violence compared with their heterosexual peers. The risk of experiencing violence is even higher for undocumented and racial/ethnic minority LGBTQ.¹⁵

**Being LGBTQ Is Not a Mental Disorder**

All major professional mental health organizations have affirmed that homosexuality is NOT a mental disorder. Being transgender or gender variant is NOT a mental illness and does not imply any impairment in judgment, stability, reliability, or general social or vocational capabilities.¹⁹

To learn about best practices for treating diverse populations and to get answers to your questions by leading psychiatrists, please visit APA’s Cultural Competency webpage at https://www.psychiatry.org/psychiatrists/cultural-competency.

**Resources**

- AMA LGBT Advisory Committee http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee.page?
- American Psychiatric Association – Toolkit for Working with Transgender and Gender-Variant Individuals
- American Psychiatric Association – Resource Document on Working with Transgender Individuals
- Association of Gay and Lesbian Psychiatrists (AGLP)  www.aglp.org
- Center for Excellence in Transgender Health  http://transhealth.ucsf.edu/
- Gay and Lesbian Alliance Against Defamation, www.glaad.org
- Gay & Lesbian Medical Association  www.glma.org
- Institute of Medicine Report - The Health of Lesbian, Gay, Bisexual, and Transgender People
- LGBT Suicide Prevention, www.thetrevorproject.org
- National Center for Transgender Equality, www.nctequality.org
- Parent, Families, and Friends of Lesbians and Gays  www.pflag.org
- The National LGBT Health Education Center  www.lgbthealtheducation.org/
- World Professional Association for Transgender Health (WPATH) www.wpath.org
Footnotes


This resource was prepared by the Division of Diversity and Health Equity. Updated and reviewed, respectively, by Jeremy Kidd, M.D., and the Council on Minority Mental Health and Heath Disparities.
Hispanic and Latino Population

The U.S. Hispanic/Latino community is very diverse and includes people from many different nations and races. While many have lived in the U.S. for many generations, others are recent immigrants who may face inequities in socioeconomic status, education, and access to health care services. There are many misconceptions and stereotypes about who is considered Latino, including the difference between the terms “Latino” and “Hispanic.”

- **Hispanic**: usually refers to language and those whose ancestry comes from Spain or Spanish-speaking countries.
- **Latino**: usually refers to geography and specifically, to Latin America which includes individuals from the Caribbean, South America, and Central America.
- More than 17.6% of the U.S. population (56.6 million) self-identify as Hispanic or Latino, making people of Hispanic origin the nation’s largest racial/ethnic minority. 

- From 2015 to 2016, Hispanic population grew by 2% (up to 57.5 million) in the U.S. By 2060, Hispanics are expected to make up 30% of the total population (129 million).
- Hispanics are the youngest major racial/ethnic group in the U.S.: 1/3 of the nation’s Hispanic population is younger than 18.
- Approximately 16.4% of Hispanics in the U.S. held a bachelor’s degree or higher in 2016, compared with 37.3% for non-Hispanic whites and 23.3% for non-Hispanic blacks.
Mental Health, Utilization of Services, and Disparities:

- Hispanics are at lower risk of most psychiatric disorders compared with non-Hispanic whites. 7
- U.S.-born Hispanics report higher rates for most psychiatric disorders than Hispanic immigrants. 4
- Studies have shown that older Hispanic adults and Hispanic youth are especially vulnerable to psychological stresses associated with immigration and acculturation. 5
- Approximately 1 in 10 Hispanics with a mental disorder use mental health services from a general health care provider, while only 1 in 20 receive such services from a mental health specialist. 6
- Hispanics are more likely to report poor communication with their health provider. 5
- Several studies have found that bilingual patients are evaluated differently when interviewed in English as opposed to Spanish and that Hispanics are more frequently undertreated.
- Nationally, 21.1% of Hispanics are uninsured, compared with 7.5% of White non-Hispanic Americans. 7,8 Low rates of insurance coverage for Hispanic is likely to be a function of ethnicity, immigration status, and citizenship status.

Disparities in Hispanic/Latino Children and Adolescents

- Hispanic children and adolescents are at significant risk for mental health problems, and in many cases at greater risk than white children. 9
- Among Hispanic students in grades 9-12 in 2015: 18.9% had seriously considered attempting suicide, 15.7% had made a plan to attempt suicide, 11.3% had attempted suicide, and 4.1% had made a suicide attempt that resulted in an injury, poisoning, or overdose that required medical attention. These rates were consistently higher in Hispanic students than in white and black students. 10
- In 2014, Hispanic and white adolescents aged 12-17 in the U.S. were more likely than black or Asian adolescents to have initiated alcohol use or cigarette use in the past year. About 10% of white and Hispanic adolescents initiated alcohol use, compared with 7.3% for blacks and 4.7% for Asian. Approximately 3.9% of Hispanic adolescents initiated cigarette use, compared
with 3.5% for white adolescents, 2.2% for black adolescents, and 1.5% for Asian adolescents. 11

• Hispanic adolescents are half as likely than white adolescents to use antidepressants. 12

• Hispanic children are half as likely as white children to use stimulants to treat disorders such as attention deficit/hyperactivity disorder (ADHD) and attention deficit disorder (ADD). 13

Barriers to Accessing Mental Health Care

• Lack of insurance or inadequate insurance

• Lack of knowledge/awareness about mental health problems and services available

• Cultural stigma associated with mental illness

• Language

• Lack of culturally tailored services and culturally competent mental health professionals

• Shortage of bilingual or linguistically trained mental health professionals

• Difficulties recognizing incipient signs of mental illness

• Problems identifying psychiatric symptoms when chief complaint is somatic symptom

To learn about best practices for treating diverse populations and to get answers to your questions by leading psychiatrists, please visit APA’s Cultural Competency webpage at https://www.psychiatry.org/psychiatrists/cultural-competency.

Resources

• National Council of la Raza (NCLR) www.nclr.org

• National Hispanic Medical Association www.nhmamd.org

• American Society of Hispanic Psychiatry (ASHP) http://americansocietyhispanicpsychiatry.com/

• National Alliance for Hispanic Health (NAHH) http://www.healthyamericas.org

• National Alliance on Mental Illness (NAMI) www.nami.org

• Mental Health America (MHA) http://www.mentalhealthamerica.net

• League of United Latin American Citizens (LULAC) www.LULAC.org

• U.S. Department of Health and Human Services Office of Minority Health https://minorityhealth.hhs.gov
Footnotes


This resource was prepared by the Division of Diversity and Health Equity. Updated and reviewed, respectively, by Maria Jose Lisotto, M.D., and the Council on Minority Mental Health and Health Disparities.
Introduction

Gay men experience adverse mental health outcomes including mood disorders, substance use and suicide more frequently than heterosexual men. They also face additional barriers to accessing mental health treatment. Adverse outcomes are linked to family rejection, systemic discrimination and internalized homophobia. Barriers to treatment include prior negative experiences with clinicians regarding sexual identity, socioeconomic status and marginalized status.

Epidemiology and Homosexuality

• Estimates of the prevalence of men who identify as homosexual vary from 1.3%1 to 5.8%2 depending on the manner in which surveys are structured and administered. The range of reported prevalence depends on the manner in which surveys are structured and administered3. For example, studies that employ the expression of men who have sex with men (MSM) do not stratify out the experiences of men who identify exclusively as homosexual, bisexual or otherwise.

• Focusing exclusively on sexual practices to categorize identity prevents clinicians from understanding social and personal facets of sexual identity3. Ongoing research is underway to understand sexual orientation as a multidimensional concept 4.

Mental Health Status and Disparities

• Gay men in comparison to heterosexuals display increased rates of mood and anxiety disorders5. Gay men are more likely to report suicidal ideation, plans, attempts in their lifetime in comparison to heterosexual men6.

• One in six gay men have made one suicide attempt in their lifetime7. (See Figure 3). Most common causes of depression are prejudice events, expectations of rejection and discrimination, concealment of identity and internalized homophobia8.

• Gay men display higher rates of substance use compared to heterosexual men (Table 4)9. Minority patient populations encounter more systemic barriers and stigma which studies show...
increases the risk of developing a substance use disorder\textsuperscript{10}.

- Additionally couples may face stressors that differ from those experienced by an individual. These can include stress related to disclosing relationships to family, concerns for being safe in public spaces, feeling judged as a same-sex couple and stress related to unequal legal rights\textsuperscript{11}. Gay Couples looking to adopt a child report increased levels of mood and anxiety disorders in contexts with increased systemic discrimination and decreased social\textsuperscript{12}.

Stigma & Discrimination

- The minority stress model refers to the conflict between the values of members of a minority group in relation to dominant values within the broader social environment\textsuperscript{13}. Where predominant social norms stigmatize homosexuality, gay men encounter more stigma and discrimination. These experiences in turn lead to adverse mental health outcomes\textsuperscript{14}.

- Discrimination towards gay men can affect access to work, health insurance and financial stability. Additionally, patients may find it harder to disclose identity to healthcare providers and access health and social supports\textsuperscript{15}. Experiencing discrimination increases risk of adverse health outcomes including HIV acquisition and decreased use of the healthcare system\textsuperscript{16}.

- Internalized homonegativity refers to the direction of negative social attitudes about homosexuality toward the self, leading to a devaluation of the self and poor self regard\textsuperscript{17}. Negative public perceptions of gay men can lead to negative attitudes towards oneself. Negative self worth occurs more often in single men\textsuperscript{18}. Non-white men who identify as gay more often report feelings of internalized homophobia\textsuperscript{18}.
Barriers to accessing Mental Health Services

- Gay men are more likely to report increased dissatisfaction and use of mental health services than heterosexuals. Patients report dissatisfaction when a clinician acts judgemental of same-sex activity, maintains anti-gay attitudes and/or displays a lack of knowledge around health concerns specific to the gay community.
- African American and Hispanic males report decreased access and use of mental health services. This has been linked to variation in socioeconomic status as well as increased social discrimination. Social discrimination is linked to decreased service use, social isolation and worsening of psychological symptoms.

References

3. Steinmetz K. Inside the efforts to finally identify the size of the nation’s LGBT population. Time Magazine.
Appalachian Population

- Approximately 8% of the U.S. population (24.9 million Americans) lives in the Appalachian Region.¹

- The Appalachian Region, as defined by the federal government, extends over 1,000 miles into 13 states, from part of Mississippi in the south to New York state in the north.

- Approximately 42% of the region’s population is rural, compared with 20% of the national population.

- During 2011-2015, the poverty rate in Appalachia was 17.1% (the national poverty rate is 14.7%), and 87% of the region’s 420 counties had more than 1.5 times the U.S. poverty rate.

- The rate of uninsured Appalachians under age 65 is 18.2% in rural counties, compared to 14.7% in the Region’s large metro counties and 12% nationally.¹ ²

- Approximately 10% of Appalachians held a bachelor’s degree or higher in 2010, compared to 25% in the general U.S. population. 23% of Appalachians did not complete high school, compared to 13% in the general U.S. population.³

Social determinants of health are the conditions in which people are born, grow, live, work, and age.⁴ The table below indicates that counties in Appalachia experience disproportionately adverse living conditions, when compared to the nation. Appalachian counties are over-represented in the nation’s worst quintile for four of the five measures of social determinants of health.

### Distributions of Social Determinants Indicators among National Quintiles for Appalachian Counties.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Best Quintile</th>
<th>2nd Best Quintile</th>
<th>Middle Quintile</th>
<th>2nd Worst Quintile</th>
<th>Worst Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median household income</td>
<td>#</td>
<td>Pct.</td>
<td>#</td>
<td>Pct.</td>
<td>#</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>5%</td>
<td>33</td>
<td>8%</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>118</td>
<td>28%</td>
<td></td>
<td></td>
<td>159</td>
</tr>
<tr>
<td>Household poverty</td>
<td>17</td>
<td>4%</td>
<td>52</td>
<td>12%</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>134</td>
<td>32%</td>
<td></td>
<td></td>
<td>122</td>
</tr>
<tr>
<td>Disability</td>
<td>9</td>
<td>2%</td>
<td>19</td>
<td>5%</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>130</td>
<td>31%</td>
<td></td>
<td></td>
<td>203</td>
</tr>
<tr>
<td>Education: some college</td>
<td>20</td>
<td>5%</td>
<td>39</td>
<td>9%</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>128</td>
<td>30%</td>
<td></td>
<td></td>
<td>150</td>
</tr>
<tr>
<td>Social associations</td>
<td>45</td>
<td>11%</td>
<td>89</td>
<td>21%</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>98</td>
<td>23%</td>
<td></td>
<td></td>
<td>86</td>
</tr>
</tbody>
</table>

Data source for authors’ calculations shown above. Appalachian_Health_Disparities_Data.xlsx. The number of counties across all five quintiles for each indicator may not sum to 420 due to missing or suppressed values.
Health Status and Disparities

• Heart disease has a 17% higher mortality rate in Appalachia, compared to the nation as a whole.

• Compared to national averages, cancer diagnosis is 10% higher in Appalachia, COPD is 27% higher, accidental injury is 33% higher, stroke is 14% higher, and diabetes is 11% higher.\(^1\)

• The infant mortality rate in the Appalachian Region is 16% higher than in the general population.\(^1\)

• The availability of dentists per 100,000 population in Appalachia is 26% lower than the national average. There is a growing number of emergency department visits for conditions related to poor oral health care.\(^1, 5\)

Mental Health Status and Disparities

• Except for alcohol consumption, Appalachians have disproportionately higher rates of mental health problems, compared to the U.S. population.\(^1\) The reason for lower consumption could be due to religious beliefs, or preference (more educated people tend to drink wine), or opioid use overtaking alcohol use in this region.

• Appalachian Medicare recipients reported feeling depressed at a rate 16.7 higher than in other U.S. regions.\(^1\)

• Localized studies of Appalachian women seeking care from Primary Care Providers yield rates as high as 44%.\(^6\)

• The region’s suicide rate is 17% higher than the national rate, and residents in Appalachia’s rural counties are 21% more likely to commit suicide than those living in the region’s large metro counties.\(^1\)

• Between 2008-2014, the mortality rate in Appalachia from poisoning (which includes drug overdoses) was 37% higher than the national rate.\(^1\)

• Appalachian Kentucky has a poisoning mortality rate (including opioid overdose) of 35.9 per 100,000 people, the highest rate in the Appalachian Region and more than double the national rate.\(^1\)

• The higher rate of opioid use in Appalachia is due to a combination of geographic and cultural factors, including: isolated and mountainous terrain limiting access to care, lack of economic opportunity, the view of addiction as a moral failing, and a shortage of mental health providers.\(^7\) There was also deliberate targeting of Appalachia by the pharmaceutical manufacturers of opioids with increased advertising and provision of samples.\(^8\)

• Data from the Centers for Disease Control’s Behavioral Risk Factor Surveillance System (BRFSS) from 2014 indicate that the average resident in Appalachia reports feeling mentally unhealthy 14% more days than the average American.\(^1\)

• Appalachian counties with greater numbers of mentally unhealthy days have higher unemployment, poverty, disability, and mortality rates, as well as lower high school graduation rates.\(^9\)
The distributions of the Behavioral Health indicators among national quintiles for Appalachian counties are shown in the table below.

### Distributions of Behavioral Health Indicators among National Quintiles for Appalachian Counties.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Best Quintile</th>
<th>2nd Best Quintile</th>
<th>Middle Quintile</th>
<th>2nd Worst Quintile</th>
<th>Worst Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>Pct.</td>
<td>#</td>
<td>Pct.</td>
<td>#</td>
</tr>
<tr>
<td>Depression prevalence</td>
<td>22</td>
<td>5%</td>
<td>54</td>
<td>13%</td>
<td>69</td>
</tr>
<tr>
<td>Suicide incidence</td>
<td>46</td>
<td>11%</td>
<td>69</td>
<td>16%</td>
<td>108</td>
</tr>
<tr>
<td>Excessive drinking</td>
<td>202</td>
<td>48%</td>
<td>92</td>
<td>22%</td>
<td>82</td>
</tr>
<tr>
<td>Poisoning mortality</td>
<td>24</td>
<td>6%</td>
<td>31</td>
<td>7%</td>
<td>56</td>
</tr>
<tr>
<td>Opioid prescriptions</td>
<td>51</td>
<td>12%</td>
<td>77</td>
<td>18%</td>
<td>91</td>
</tr>
</tbody>
</table>

Data source for authors’ calculations shown above. Appalachian_Health_Disparities_Data.xlsx. The number of counties across all five quintiles for each indicator may not sum to 420 due to missing or suppressed values.

### Adverse Childhood Experiences (ACE) and Rural America

ACEs are significant disturbances in a child’s life that impact her or his ability to function in healthy ways. They were initially investigated in 1998 by CDC-Kaiser Permanente’s Adverse Childhood Experiences (ACE) study to examine the link between ACEs and physical and mental health outcomes.9

- ACEs include all forms of child abuse (emotional, physical, or sexual), neglect (physical or emotional), or household dysfunction (divorce, violence, incarceration, substance abuse, or mental illness).
- Findings of the study indicated that the more ACEs a child experienced, the greater the risk of chronic health conditions, anxiety disorders, low life potential, and even early death.
- As the number of ACEs increases, so does the risk for negative health outcomes.
- In a study of rural and urban children and adults, the prevalence of ACEs was comparable in rural and urban children and adults. 56.5% of rural adults surveyed reported having ACE exposure. Among those with any ACE history, 25.8% experienced four or more ACEs. Thus, people who report having an ACE are at higher risk of having more than one ACE.11

### CDC Mortality Rates in the United States and Southwest Virginia

<table>
<thead>
<tr>
<th>Form of mortality</th>
<th>U.S.</th>
<th>SW VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional injury in white males</td>
<td>45</td>
<td>73-163</td>
</tr>
<tr>
<td>Unintentional injury in white females</td>
<td>18</td>
<td>23-28</td>
</tr>
<tr>
<td>Motor vehicle accidents white males</td>
<td>26</td>
<td>43-98</td>
</tr>
<tr>
<td>Motor vehicle accidents white females</td>
<td>11</td>
<td>15-19</td>
</tr>
<tr>
<td>Homicide white males</td>
<td>9</td>
<td>9-37</td>
</tr>
<tr>
<td>Homicide white females</td>
<td>3</td>
<td>4-21</td>
</tr>
<tr>
<td>Firearm homicide white males</td>
<td>6</td>
<td>7-29</td>
</tr>
<tr>
<td>Firearm homicide white females</td>
<td>1.4</td>
<td>2-10</td>
</tr>
<tr>
<td>Firearm suicide white males</td>
<td>13</td>
<td>23-74</td>
</tr>
</tbody>
</table>

- Exposure to adverse events in Appalachia occurs throughout the life span. The rate of violent mortality in Southwest Virginia is 2 to 4 times higher than the US as a whole based on data from the CDC.
- In a study of psychiatric patients in Southwest Virginia see via telepsychiatry 65% reported experiencing significant trauma with the majority experiencing childhood trauma, but 15% had been assaulted as adults and 11% had witnessed severe of fatal violence.12
Mental Health Service Utilization

In Appalachia the number of mental healthcare professionals per 100,000 residents was 35% lower than the national average. In the southern and north central sub-regions of Appalachia, it further decreases to 50% fewer mental healthcare professionals than the national average.\(^1\)

Barriers to Accessing Mental Health Services

Key barriers to accessing mental health treatment for Appalachian people include:

- Distance to treatment facilities\(^{13,14}\)
- Access to transportation\(^{15}\)
- Shortage of treatment providers\(^1\)
- Rural Appalachian values of individualism and self-reliance.\(^{16}\)

- A long and troubled history between local Appalachians and absentee land-owning and exploitative corporations (e.g., timber, coal) has fostered a lingering skepticism of “outsiders,” and this extends to medical and mental health care.\(^{17,18}\)

Cultural Health Practices of Appalachian People

- Folk medicine has historically been important in the treatment of Appalachian communities. This approach was based on available resources and grew out of necessity, due to extreme geographic isolation and the lack of traditional medical care available to the population for the first century of settlement.\(^{18}\) Examples include herbal and homemade remedies such as ginseng to treat kidney problems, jimsonweed for asthma, and goldenseal for indigestion.\(^{19}\) Ethnographic research shows that the use of botanically based home remedies are being replaced by items occurring around the home, such as turpentine, gasoline, kerosene, ashes, stove soot, sulfur, and to an even greater degree commercial products are commonly reverted to for many “ordinary” health concerns, such as aspirin, Vick’s, Listerine, Vaseline, Doan’s Kidney Pills, etc.\(^{20}\) These practices are still quite important, because health care which is more readily available is often too expensive for the large uninsured population. Prescription drugs are often out of reach and professional health care is usually only sought in more extreme situations.\(^{21-22}\)

- Protective Factors in Appalachia are embedded into the cultural fabric of people in the Appalachian Region. Protective Factors include strong spiritual beliefs and a commitment to family and community above self. The region’s relative geographical isolation created self-sufficiency, creative problem-solving, and strong bonds among neighbors. Many people fear that through continued poverty and out-migration, as well as the damage of the opioid epidemic that these values are being threatened.\(^{23}\)

- The absence of outside cultural influences helped create a sense of egalitarianism and humility.\(^{24}\) Hospitality is a top priority in this region, both due to religious and geographic influences.

Strengths and Protective Factors Common to Appalachian People

- Family
- Self-reliance
- “Love of Place”\(^{25}\)
- Spiritual beliefs and practices
- Acceptance that life is difficult
- Patriotism\(^{25}\)
- Egalitarianism\(^{24}\)
- Culture of honor, where being worthy of one’s family, community, nation, or God is a primary motivator for action
- Humility is a virtue, “pride precedes the fall”
Resources

- Mental Health America (MHA)  
  www.mentalhealthamerica.net
- National Alliance on Mental Illness (NAMI)  
  www.nami.org
- National Association for Rural Mental Health (NARMH)  
  www.narmh.org
- Adverse Childhood Experiences (ACES) -  
  Journal articles, BRFSS ACE data, and other ACE resources from the Centers for Diseases & Control and Prevention  
  www.cdc.gov/violenceprevention/acestudy/index.html

References


American Indian and Alaska Native Population

• Approximately 2% of the U.S. population – 6.6 million Americans – self identify as having American Indian/Alaska Native (AI/AN) heritage.¹

• About two-thirds live in urban, suburban, or rural non-reservation areas; about one-third live on reservations.¹

• As of 2017, there are currently 567 federally-recognized AI/AN tribes; they are culturally diverse and speak more than 200 languages.¹

• Newly born AI/ANs have a life expectancy that is 4.4 years less than the rest of the nation—73.7 years compared with 78.1 years, respectively).²

• AI/ANs have the highest poverty rate of any race/ethnic group, with 26.6% living in poverty (The national poverty rate is 14.7%).¹

• Approximately 21% of single-race AI/ANs lack health insurance coverage in 2015 as compared with 9.4% of the general US population who lacked health insurance coverage.¹

Population Distribution of American Indians/Alaska Natives in the U.S.
Mental Health Status and Disparities

Research indicates that AI/AN populations have disproportionately higher rates of mental health problems than the rest of the US population.\(^2\)

High rates of substance use disorders (SUDs), posttraumatic stress disorder (PTSD), suicide, and attachment disorders in many AI/AN communities have been directly linked to the intergenerational historical trauma forced upon them, such as forced removal off their land and government-operated boarding schools which separated AI/AN children from their parents, spiritual practices, and culture.\(^4\)

- In 2014, approximately 21% of AI/ANs ages 18 and up reported past-year mental illness, compared with 17.9% for the general population.\(^5\)
- AI/AN children and adolescents have the highest rates of lifetime major depressive episodes and highest self-reported depression rates than any other ethnic/racial group.
- In 2014, suicide was the second leading cause of death for AI/ANs between the ages 10 and 34. Suicide was the leading cause of death for AI/AN girls between ages of 10 and 14; in AI/AN females from ages 15 to 19, rates of completed suicides were almost 4 times higher than white females counterparts.\(^6\)
- In 2014, approximately 9% of AI/ANs ages 18 and up had co-occurring mental illness and substance use disorder in the past year—almost three times that of the general population.\(^5\)
- The overall rate of alcohol consumption among AI/AN (43.9%) is significantly lower than the national average (55.2%). However, there are differences by age and region and tribe, with some tribes having distinctly higher and lower rates.\(^6\)
- National data shows a higher prevalence and earlier initiation of drug and alcohol use among AI/AN youth ages 17 and younger, compared with all other races/ethnicities.\(^2\)

Mental Health Service Utilization

Mental health service utilization rates for AI/ANs are low, which is likely due to a combination of factors, including stigmatization of mental health, lack of culturally trained providers, and lack of available services.\(^7\)

Cultural Health Practices of American Indians/Alaska Natives

Traditional healing systems are important in the treatment of AI/AN communities. These systems focus on balancing mind, body, and spirit via a connection with place and land.\(^8\) Some AI/AN populations believe that traditional-based healing practices have potential to help address mental health care needs within their communities. Research shows that Indigenous men and women who meet criteria for depression/anxiety or substance use disorder are significantly more likely to seek help from traditional/spiritual healers than from other sources.\(^9,10\)

Protective Factors are concepts that are key to the “cultural context, identity, adaptability, and perseverance” of AI/ANs. Protective Factors includes holistic approaches to life, a desire to promote the well-being of the group, an enduring spirit, and respect for all ways of healing.\(^11,12\)

Strengths and protective factors common to AI/ANs include:

- A strong identification with culture
- Family
- Enduring spirit (stubborn, hard to accept change)
- Connection with the past
- Traditional health practices (e.g., ceremonies)
- Adaptability
- Wisdom of elders
Some key protective factors against suicide attempts among AI/AN youth include: 13

• Discussion of problems with family or friends,
• Connectedness to family
• Emotional health

Barriers to Accessing Mental Health Services

Key barriers to accessing mental health treatment for AI/ANs include:

• Economic barriers (cost, lack of insurance)
• Lack of awareness about mental health and available services
• Stigma associated with mental illness
• Lack of culturally sensitive mental health services
• Mistrust of health care providers
• Lack of appropriate intervention strategies (including integration of mental health and primary health care services)

To learn about best practices for treating diverse populations and to get answers to your questions by leading psychiatrists, please visit APA’s Cultural Competency webpage at https://www.psychiatry.org/psychiatrists/cultural-competency.

Resources

• The National Center for American Indian and Alaska Native Mental Health Research-http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/NCAIANMHR/Pages/ncaianmhr.aspx
• Indian Health Service/Behavioral Health- https://www.ihs.gov/communityhealth/behavioralhealth/
• National Indian Health Board- http://www.nihb.org/
• Urban Indian Health Institute-http://www.uihi.org/
• One Sky Center American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services- http://www.oneskycenter.org/
• National Council on Urban Indian Health-https://www.ncuih.org/index
• Kaiser Family Foundation – Health and Health Care for American Indians and Alaska Natives
• SAMHSA American Indian/Alaska Native Culture Card-https://store.samhsa.gov/shin/content/SMA08-4354/SMA08-4354.pdf
• Facts for Features – American Indian and Alaska Native Heritage Month: November- https://www.census.gov/newsroom/facts-for-features.html
Footnotes


7 Substance Abuse and Mental Health Services Administration, Tribal Technical Advisory Committee, Indian Health Services, National Indian Health Board. National Tribal Health Agenda. Rockville, MD: SAMHSA, 2016.


This resource was prepared by the Division of Diversity and Health Equity. It was updated by Mira Zein, M.D., M.P.H, and reviewed by Mary Roessel, M.D. and the Council on Minority Mental Health and Health Disparities.
African American Population

• African Americans make up 13.3% of the US population.¹

• African American communities across the US are culturally diverse, with immigrants from African nations, the Caribbean, Central America, and other countries.

• About 27% of African Americans live below the poverty level compared to about 10.8% of non-Hispanic whites.²

• Approximately 30% of African American households are headed by a woman with no husband present, compared with about 9% of white households.³

Health Challenges

• Approximately 11% of African Americans are not covered by health insurance, compared with about 7% for non-Hispanic whites.⁴

• Death rate for African Americans is higher than whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.⁵

• CDC estimates that African Americans represented more than one-third (40% or 498,400 persons) of all people living with HIV and almost half (45%) of all persons with newly diagnosed infection in 2015.⁶
Mental Health Status, Use of Services, and Disparities

- Rates of mental illnesses in African Americans are similar with those of the general population. However, disparities exist in regard to mental health care services. African Americans often receive poorer quality of care and lack access to culturally competent care.\(^7\)

- Only one-in-three African Americans who need mental health care receives it.\(^8\)

- Compared with non-Hispanic whites, African Americans with any mental illness have lower rates of any mental health service use including prescriptions medications and outpatient services, but higher use of inpatient services.\(^9\)

- The rate of illicit drug use among African Americans is slightly higher than the national average (12.4% vs 10.2%). Rate of alcohol use is slightly lower than the national average (44.2% vs 52.7%) including heavy drinking (4.5% vs 6.2%) and binge drinking (21.6% vs 23%).\(^10\)

- Rate of opioid overdose among African Americans (6.6%) is less than half of that for non-Hispanic whites (13.9%).\(^11\)

- Compared with whites, African Americans are:
  - Less likely to receive guideline-consistent care
  - Less frequently included in research
  - More likely to use emergency rooms or primary care (rather than mental health specialists).\(^12\)
• Compared with the general population, African Americans are less likely to be offered either evidence-based medication therapy or psychotherapy.13

• Compared with whites with the same symptoms, African Americans are more frequently diagnosed with schizophrenia and less frequently diagnosed with mood disorders. Differences in how African Americans express symptoms of emotional distress may contribute to misdiagnosis.14

• Physician-patient communication differs for African Americans and whites. One study found that physicians were 23% more verbally dominant, and engaged in 33% less patient-centered communication with African American patients than with white patients.15

• Black people with mental health conditions, particularly schizophrenia, bipolar disorders, and other psychoses are more likely to be incarcerated than people of other races.16,17

Barriers to Care

Despite recent efforts to improve mental health services for African Americans and other minority groups, barriers remain regarding access to and quality of care. The barriers include:

• Stigma associated with mental illness
• Distrust of the health care system
• Lack of providers from diverse racial/ethnic backgrounds
• Lack of culturally competent providers
• Lack of insurance, underinsurance

Other common barriers include: the importance of family privacy, lack of knowledge regarding available treatments, and denial of mental health problems. Concerns about stigma, medications, not receiving appropriate information about services, and dehumanizing services have also been reported to hinder African Americans from accessing mental health services.

To learn about best practices for treating diverse populations and to get answers to your questions by leading psychiatrists, please visit APA’s Cultural Competency webpage at https://www.psychiatry.org/psychiatrists/cultural-competency.
Footnotes


9 Substance Abuse and Mental Health Services Administration. “Racial/ Ethnic Differences in Mental Health Service Use among Adults.” 2015.


11 Kaiser Family Foundation. “Opioid Overdose Deaths by Race/Ethnicity (2012-2015).” 2017. http://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?dataView=2&activeTab=graph&currentTimeframe=0&startTimeframe=3&selectedDistributions=white-non-hispanic--black-non-hispanic--hispanic&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22coll d%22:%22Location%22,%22sort%22:%22asc%22%7D.


This resource was prepared by the Division of Diversity and Health Equity. It was updated by Phillip Murray, M.D., and reviewed by Danielle Hairston, M.D., and the Council on Minority Mental Health and Health Disparities.
Mental Health in U.S.

- Approximately 18% of US adults have a diagnosable mental disorder in a given year, and approximately 4% of adults have a serious mental illness. ¹
- Mental and behavioral disorders are among the leading causes of disability in the U.S., accounting for 13.6% of all years of life lost to disability and premature death. ²
- Mental disorders are among the top most costly health conditions for adults 18 to 64 in the U.S., along with cancer and trauma-related disorders. ³
- An estimated 43% of people with any mental illness receive mental health treatment/counseling. ⁴

Increasingly Diverse Population

The U.S. population is continuing to become more diverse. By 2044, more than half of all Americans are projected to belong to a minority group (any group other than non-Hispanic White alone). ⁵

Mental Health, Diverse Populations and Disparities

Most racial/ethnic minority groups overall have similar—or in some cases, fewer—mental disorders than whites. However, the consequences of mental illness in minorities may be long lasting.

- Ethnic/racial minorities often bear a disproportionately high burden of disability resulting from mental disorders.
- Although rates of depression are lower in blacks (24.6%) and Hispanics (19.6%) than in whites (34.7%), depression in blacks and Hispanics is likely to be more persistent. ⁶
- People who identify as being two or more races (24.9%) are most likely to report any mental illness within the past year than any other race/ethnic group, followed by American Indian/Alaska Natives (22.7%), white (19%), and black (16.8%).
- American Indians/Alaskan Natives report higher rates of posttraumatic stress disorder and alcohol dependence than any other ethnic/racial group.
- White Americans are more likely to die by suicide than people of other ethnic/racial groups.
Mental health problems are common among people in the criminal justice system, which has a disproportionate representation of racial/ethnic minorities. Approximately 50% to 75% of youth in the juvenile justice system meet criteria for a mental health disorder.7

Racial/ethnic minority youth with behavioral health issues are more readily referred to the juvenile justice system than to specialty primary care, compared with white youth. Minorities are also more likely to end up in the juvenile justice system due to harsh disciplinary suspension and expulsion practices in schools.8

Lack of cultural understanding by health care providers may contribute to underdiagnosis and/or misdiagnosis of mental illness in people from racially/ethnically diverse populations. Factors that contribute to these kinds of misdiagnoses include language differences between patient and provider, stigma of mental illness among minority groups, and cultural presentation of symptoms.

Disparities in Mental Health Service Use

People from racial/ethnic minority groups are less likely to receive mental health care. For example, in 2015, among adults with any mental illness, 48% of whites received mental health services, compared with 31% of blacks and Hispanics, and 22% of Asians.9

There are differences in the types of services (outpatient, prescription, inpatient) used more frequently by people of different ethnic/racial groups. Adults identifying as two or more races, whites, and American Indian/Alaska Natives were more likely to receive outpatient mental health services and more likely to use prescription psychiatric medication than other racial/ethnic groups. Inpatient mental health services were used more frequently by black adults and those reporting two or more races. Asians are less likely to use mental health services than any other race/ethnic group.10

Among all racial/ethnic groups, except American Indian/Alaska Native, women are much more likely to receive mental health services than men.10

Any Mental Illness in the Past Year among Adults, by Race/Ethnicity, 2008-2012

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>19.0</td>
</tr>
<tr>
<td>Black or African American</td>
<td>16.8</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>13.4</td>
</tr>
<tr>
<td>Asian</td>
<td>24.9</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>15.3</td>
</tr>
</tbody>
</table>

Among People with Any Mental Illness, Percent Receiving Services, 2015

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>48%</td>
</tr>
<tr>
<td>Black</td>
<td>31%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>31%</td>
</tr>
<tr>
<td>Asian</td>
<td>22%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>46%</td>
</tr>
</tbody>
</table>
Barriers to Care

Factors affecting access to treatment by members of diverse ethnic/racial groups may include:

- Lack of insurance, underinsurance
- Mental illness stigma, often greater among minority populations
- Lack of diversity among mental health care providers
- Lack of culturally competent providers
- Language barriers
- Distrust in the health care system
- Inadequate support for mental health service in safety net settings (uninsured, Medicaid, Health Insurance Coverage other vulnerable patients)

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Footnotes


8 Substance Abuse and Mental Health Services Administration. Emerging Issues in Behavioral Health and the Criminal Justice System.


10 Substance Abuse and Mental Health Services Administration. Racial/Ethnic Differences in Mental Health Service Use among Adults. 2015.

This resource was prepared by the Division of Diversity and Health Equity and Division of Communications, and reviewed by the Council on Minority Mental Health and Health Disparities.