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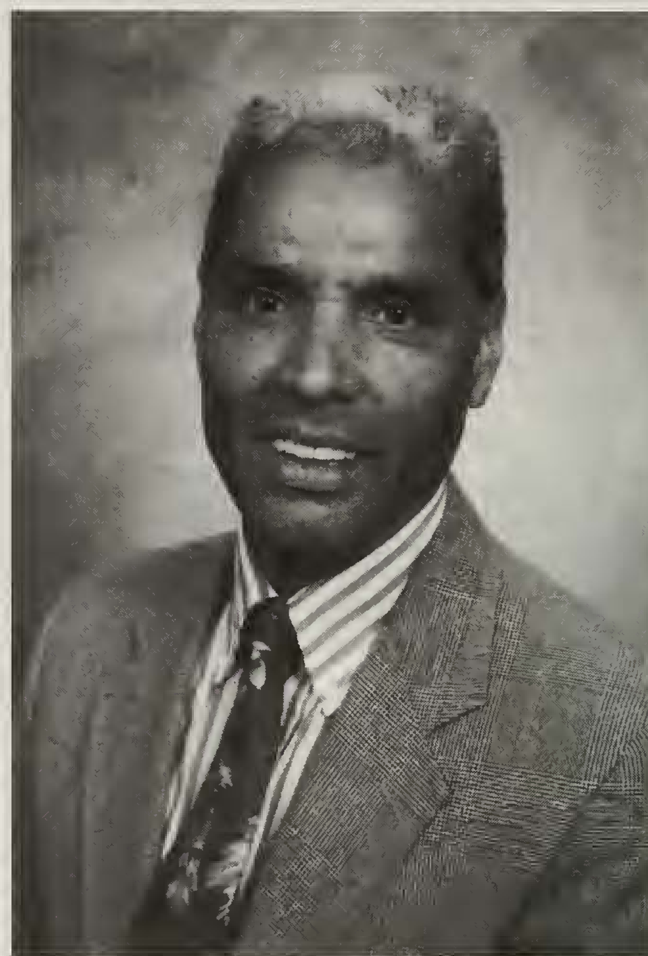
The Multicultural Mental Health Research Center (MMHRC)

by Castellano Turner



Background

African Americans, Asian Americans, Hispanic/Latino Americans, and Native Americans have had relatively less access to the resources of society compared to white Americans. These resources include such things as educational and employment opportunities, political and economic power, and the goods and services that a prosperous society can produce. Health care is an important resource to which access is not equal for all groups. African Americans and other ethnic minority groups are, by most indices of health care access and utilization, underserved. Mental health services, in particular, have been shown to be less available to ethnic minority populations. Jones and Korchin, and Turner and Kramer, have demonstrated that, although the needs for mental health services are predictably greater among ethnic minority groups, access to the highest quality services has been less than that for whites.[1] Minorities have briefer stays in mental health inpatient facilities but significantly more re-hospitalizations.[2] Minorities are treated primarily with drugs rather than psychotherapy. Geller has presented persuasive evidence for a systematic bias against the acceptance of African American clients into psychotherapy.[3]

Although the disparities are observable and significant, it is not clear what they mean or what should be done in response to them. Among the questions suggested by this observation are these: Are the mental health service needs of ethnic minority groups greater, less, or simply different from those of the majority population? What part does racism (in its various forms) play in creating barriers to adequate mental health services? What role does culture play in the creation, maintenance, or solution to mental health problems? Is the primary barrier to adequate services for ethnic minorities to be found in the attitudes and behavior of clients or in those of practitioners? Are the larger systems — institutions, communities, political structures, society as a whole — the real sources of the discrepancy between need and access? And is it at those levels that we should look for solutions and aim our interventions (e.g. at policies instead of people)? Is it that we do not have the right practitioners to provide the services? There is certainly an inadequate supply of mental health service providers of color at present and for the foreseeable future. On the other hand, we have elsewhere found that minority professionals are significantly more likely to provide mental health services to clients of color than are majority group professionals.[4] But, assuming no radical shifts in occupational choice and opportunities, should we concentrate on training non-minority mental health service providers to be more accessible and better prepared to provide services to an increasingly multicultural population? In doing this how must we modify the content and models of our training?

It is not the purpose of this essay to attempt to answer these questions. All are important, but we could spend more than one journal article addressing any one of them. These questions, however, suggest the context and the need for the development of research centers dedicated to understanding the mental health needs of ethnic minority populations in the United States.

Almost two decades ago the National Institute of Mental Health (NIMH) began one type of response by introducing a program which was intended to answer some of the need for research. The Minority Mental Health Research Center Grants Program was a major acknowledgement of the importance of the questions about the special mental health service needs of American ethnic minority communities. The funding for the centers was to support both research infrastructure within universities and research programs specifically focused on the mental health of minority populations. The universities which have received funding under this program have typically been large research institutions in urban areas or in close vicinity to communities of color and have focused on individual ethnic groups. The centers are focused on research with Asians (e.g. UCLA), Hispanic/Latinos (e.g. Fordham University), and African Americans (University of Michigan). None of these centers is located in New England, and only New York City's Fordham University is in the north.

Multicultural Mental Health Research Center at the Trotter Institute

In 1990, Wornie Reed, former director of the Trotter Institute and chair of the Black Studies Department brought together a group of University of Massachusetts Boston faculty (primarily African Americans from a variety of departments) to collaborate on a Minority Mental Health Center proposal under the Trotter Institute. The proposal fit the traditional model of the centers that had been funded up to that time — that is, the proposal focused on a single minority group (African Americans), it was developed out of a university, and gave relatively little attention to local agencies, community organizations, and professionals in defining its research agenda. That proposal was not successful, and interest in trying again waned as the funding for the NIMH Center's Program seemed increasingly questionable. After Wornie Reed accepted a position at another university, there seemed little energy for submitting another proposal, although those involved continued to think of a minority mental health research center as an idea whose time had come.

In Fall 1992, a dialogue began between James Jennings, director of the Trotter Institute, and Marlene Tarpley, a staff professional at the Massachusetts Department of Mental Health (DMH) central office. Ms. Tarpley had successfully organized a group of DMH staff and community mental health professionals of color into the Multicultural Advisory Committee (MAC). Among the ideas emerging from this group was the possibility of collaborating with a local university in the creation of a minority mental health research center. In the several meetings which Jennings and Tarpley organized to bring UMass Boston faculty and MAC representatives into discussions, two important ideas quickly evolved. First, the strength of the proposed minority mental health research center was in collaboration among community representatives, DMH staff, and the UMass Boston faculty. Although the rhetoric in the mental health research area has been heavy with the ideal of town-gown cooperation (even collaboration), none of the centers had managed to have a truly collaborative alliance with communities or state agencies. Among the problems had been the desire of federal agencies to have a locus of responsibility; all the better if the site had a track record of accepting and administering grants. The naturalness and appeal of the collaboration which seemed to be possible was compelling.

Second, unlike the other NIMH-funded centers, the commitment in the group was to construct a multicultural center. That is, rather than an exclusive focus on a single minority group, the proposed center would be dedicated to a broad and inclusive agenda: the mental health needs of the several United States minority groups. Among the appealing aspects of this more inclusive agenda was the further articulation and application of the theme of collaboration. Mental health professionals from the larger communities of color could, within such a center, not only join forces in the research enterprise but also answer questions about inter-ethnic variability which had been made difficult by the compartmentalized ways in which centers had been structured and organized.

Although not a defining dimension of the emerging center, we recognized early in our discussions that we were in a context of opportunity and change. The opportunity was represented in part by where we are located (in a multicultural state) and by the rich resources of research institutions and research scholars in the region. The change was represented by finding ourselves anticipating (perhaps fearing) what most observers agree will be massive changes in our health care system. Although the deinstitutionalization of the severe mentally ill had already been in process for several decades by the time we came together, the most recent manifestation of the basic theme, in the form of "privatization" of mental health services, was very relevant to our questions about the fair distribution of resources. Given the likely chaos and dislocations occasioned by such policy innovations, would communities of color find themselves neglected and put at more than usual risk? Those participating in the early planning of the Multicultural Mental Health Research Center (MMHRC) made monitoring the impact of policy changes (such as managed care) in communities of color central to the agenda.

The central focus of our early meetings was limited to planning a center to be funded by NIMH under the Minority Mental Health Centers Program. The group soon broadened its goals and made a commitment to the notion of the MMHRC without regard to NIMH funding. We felt that there was a need in the Commonwealth of Massachusetts for a center dedicated to understanding the mental health and mental health service needs in communities of color.

Over the last two years an executive board has been the major source of continuity in the MMHRC. Over that period we have been faced with a number of challenges, some of which remain. First, the ideal of collaboration between organizations can be difficult to manage. The constraints which organizations place on individual participants sometimes created impediments to making decisions. On the one hand, the idea of institutional collaboration was central to the entire undertaking. Second, we have been hampered by the lack of funding. The contributions made by the several institutions have been primarily in the form of the individuals present in the discussions. Projects requiring other resources have remained in the planning process. The board realized that funds were needed in order to work on getting more substantial support from NIMH or other funding sources.

Since 1993 the board has been working to obtain planning and infrastructure support from the UMASS Medical Center Department of Psychiatry's Center of Excellence. The Center of Excellence is funded by the Commonwealth of Massachusetts to carry out programs of research on mental health service issues. Among the mandates of the grant was the inclusion of ethnic minority concerns and participation. Recently, the MMHRC received funds to provide a part-time salary for an executive director, Kermit Crawford, a clinical

psychologist specializing in forensic services research, and to defray some of the costs heretofore absorbed by the Trotter Institute.

The board has recently begun to prepare a grant proposal to be submitted in the fall to NIMH under the Research Infrastructure Support Program. That effort has been helped by the staff of the Medical School, the leadership of DMH, and a consultant from the University of California Berkeley.

Although the process has been gradual and there continues to be uncertainty about long-term and adequate financial support, the board is confident that the MMHRC will survive both as an idea and as a place where important research will be done.

The Research Agenda

In addition to the problems of organizing and obtaining funding, the board's vision has emphasized the potential for research itself. Some of the realms of programmatic research pursued include the following:

1. **Forensic research and ethnic minority clients.** The aim of this research effort would be to create a database on the forensic treatment of minority mental health clients. Among the questions: Are minority clients more likely than others to be diverted from the mental health service system to the criminal justice system?

Such a center could serve as a clearinghouse of information about mental health issues affecting communities of color.

2. **Minority clients and managed care**. One major question that has arisen as the notion of managed health care has taken hold over the last several years is whether some categories of the population will be adversely affected by the changes in service delivery. For example, will the rate of admission, discharge, and recidivism for ethnic minorities change? How might race/ethnicity interact with other variables (such as social class, age, and gender) in determining the outcomes in managed care systems?

3. **Attitudinal barriers to services for ethnic minority clients.** Like other members in the culture, mental health professionals hold onto stereotypes of ethnic minority group clients that lead to the rejection of such clients. It is also possible that members of various ethnic minority populations hold attitudes about mental health services and providers which create barriers to the use of mental health services. The ways in which clients (including families) and providers think about each other may well explain some of the underutilization of services.

4. **Cross-cultural competence in service delivery.** Among the assumptions emerging out of debates about adequate service to minority populations is that those not sharing a similar cultural background will have difficulty in establishing a productive working relationship. If the assumption is supported, we will be faced with the problem of how to develop competence in cross-cultural work. Here the impact of various programs of training on service outcomes would be the major research question.

These are but a few of the many areas of research that could be developed at the MMHRC in the future. But a center of the type envisioned is not set up solely for gathering data. Such a center could serve as a clearinghouse of information about mental health issues affecting communities of color. Such a center might well create its own archives and develop means for systematically sharing information with the community and professional providers. For example, the MMHRC could establish its own Internet bulletin board and offer access to data and information to researchers. The educational functions of the MMHRC could have several facets. The center could be a setting for research training at all levels — professionals, post-doctoral trainees, graduate students, and undergraduates. The center could also include the gathering and construction of curricular and training materials relevant to multicultural mental health and made available to community agencies and educators.

Whatever the eventual programs of research, education, and service designed by the MMHRC, the vision will remain unchanged: a center in this region which is dedicated to research and the dissemination of information on mental health needs of all communities of color, working together, for the benefit of all people.

Notes

[1]E.E. Jones and S.J. Korchin, "Minority Mental Health: Perspectives." In. E.E. Jones & S.J. Korchin (Eds.), *Minority Mental Health*. (New York: Praeger, 1982). Also see C.B. Turner and B.M. Kramer, "Connections Between Racism and Mental Health." In C. Willie, B. Kramer, B. Brown, and J. Riecker (Eds.), *Racism, Sexism, and Mental Health*. (Pittsburgh: University of Pittsburgh Press, 1995).

[2]R.W. Manderscheid and M.A. Sonnenschein, (Eds.), *Mental Health, United States, 1990*. National Institute of Mental Health. DHHS Pub. (ADM) 90-1708. (Washington DC: U.S. Government Printing Office, 1990).

[3]J.D. Geller, "Racial Bias in the Evaluation of Patients for Psychotherapy." In L. Comas Dias and E.E. Griffith (Eds.), *Clinical Guidelines in Cross-Cultural Mental Health*. (New York: Wiley Interscience, 1988).

[4]C.B. Turner and B.F. Turner, *Who Treats Minorities?* Paper presented at the 1992 Annual Meeting of the Eastern Psychological Association, Boston, Massachusetts.

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