



**JAN/FEB/MARCH 2011  
SPRING ISSUE**

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*Includes: Featured Story  
Gangs, Depression, Suicide*

**SEAT/ASIST  
Training Dates**

January 11th and 12th 2011	
Core Group ASIST workshop	<b>SA 7</b>
Cal State Dominguez	
February 8, 2011	
SEAT Presentation/ TAY Services	<b>SA 6</b>
Providers Meeting Starview Mental Health	
February 11, 2011	
SEAT Presentation SA Executive Providers Meeting	<b>SA 7</b>
Rio Hondo MH	
March 9th, 10th 2011	
Core Group ASIST Workshop	<b>SA 4</b>
California Endowment	

To register, contact  
Tasha MFashion.Stiger  
tmcfashionstiger@dmh.lacounty.gov

# The “SERT” Buzz

*Suicide Education and Resource Tips  
Newsletter*

## The Minority Report: African-Americans and Barriers to Accessing Mental Health Services

*Source:* Regier, D. A et al; (1993). One-month prevalence of Mental Disorders in the United States and sociodemographic characteristics

The study of African-American mental health has had a long and, at times, disturbing history in the United States. Studies of racial differences in health during the 19th century were used to obscure the social origins of illness, demonstrate black inferiority, and provide a scientific rationale for policies of inequality, subjugation and exploitation of blacks (Krieger 1987). For example, one scientific report deliberately falsified the black insanity rates from the 1840 U.S. Census to show that the further north blacks lived, the higher their rates of psychosis, which further supported the myth that “freedom would make blacks go even more crazy”. Current research on black mental health is no longer characterized by such blatant racism. And today, we seemingly have better and more reliable estimates of the distribution of psychopathology within the African-American population. However, 170 years after the 1840 Census, there are still important gaps and contradictions in our knowledge of the mental health status of the African-American population and even more gaps in their access to treatment.



African-American communities across the United States are more culturally diverse now than any other time in history with increasing numbers of immigrants from African nations, the Caribbean, Central America and other countries. Despite recent efforts to improve mental health services for African-Americans and other culturally diverse groups, barriers remain in access to and quality of care from, insurance coverage to culturally competent services. According to the National Institute of Mental Health, these and other diverse communities are underserved by the nation’s mental health system. For example, one out of three African-Americans who need mental health care receives it. It is further noted that compared to the general population, African-Americans are more likely to stop treatment early and are less

likely to receive follow-up care. Many may wonder what are some of the causes and or implications of these gaps, and why does these disproportionate difference still exist today? To answer any of these questions, it is first important to understand the issue at hand as related to prevalence of mental health issues and concerns within the African-American community. The prevalence of mental disorders is estimated to be higher among African-Americans than among whites (Regier et al., 1993a). This difference does not appear to be due to intrinsic differences between the races. Rather, it appears to be due to socio-economic differences. It appears that when socio-economic factors are taken into account, the prevalence difference disappears. In other words, it is the lower socio-economic status of African-Americans that places them at higher risk for mental disorders (Regier et al., 1993a). According to the 2001 Surgeon Generals Report on *Mental Health, Cultural, Race and Ethnicity*; of the nearly 34 million people who identify themselves as

African-American, 22% of them lived in poverty. It is further noted that these individuals are at particular risk for mental health illness due to an overrepresentation in homeless populations, people who are incarcerated, children in foster care and child welfare systems, and victims of serious violent crime. Now that the prevalence and risk of mental disorders for African-Americans have been established, we must discuss the cultural and systemic barriers to accessing services.

To ensure African-American communities have access to adequate and affordable care, a better understanding of the complex role that cultural backgrounds and diverse experiences play in mental disorders in these communities is vital. Culturally diverse groups often bare a disproportionately high burden of disability resulting from mental disorders.

“....many generations were raised with the belief that black people don’t go to therapy....”



...Depression is often misdiagnosed in the African-American Community...

## The Minority Report: African-Americans (continued)

Many researchers will argue that this disparity does not stem from a greater prevalence rate or severity of illness in African-Americans, but from a lack of culturally competent care, and receiving less or poor quality care. Historically, mental health research has been based on Caucasian and European-based populations, and did not incorporate understanding of racial and ethnic group, their beliefs, traditions and value systems. Cultural identity encompasses distinct patterns of belief and practices that have implications for one’s willingness to seek treatment from, and to be adequately served by, mental health care providers. Thus, culturally competent care is crucial to improving utilization of services and effectiveness of treatment for these communities. To adequately address this issue, more research must be done to better understand mental health disparities and to develop culturally competent interventions for African-Americans.

Throughout U.S. history, the African-American community has faced inequities in accessing education, employment and health care services. Therefore, issues of distrust in the health care system and mental illness stigma frequently lead African-Americans to initially seek mental health support from non-medical sources. These non-medical sources, which often includes family, friends, clergy or religious leaders, and other community leaders, becomes their primary support system for coping with various symptoms of mental illness. Because African-Americans often turn to community family, friends, neighbors, community groups and religious leaders for help, the opportunity exists for community health services to collaborate with local churches and community groups to provide mental health care and education to families and individuals. Other barriers greatly stem from the fears, lack of understanding and stigma surrounding what it means to be diagnosed with a mental illness in the African-American community. Often those fears decrease the help-seeking behavior amongst many culturally diverse populations. Even more so for a group of individuals who for many generations were raised with the belief that “*Black people don’t go to therapy. They don’t see a psychiatrist. All they need is prayer and Jesus.*”

As widely agreed, African-Americans in need of mental health services face many barriers in receiving and accessing effective mental health treatment. These barriers can best be understood as described by the conceptual framework developed by Swanson and Ward (1995), which includes socio-cultural barriers, systemic barriers, economic barriers, and individual barriers. With no uncertainties we know that disparities continue to exist, however little is known regarding underlying factors that may contribute to many of these disparities. Additional research is needed to better understand the impact of barriers to mental health services among African-Americans on racial disparities in prevalence and incidence rates of mental illness and rates of mental health services utilization.

### Clinical Corner: A Conversation about Clinical Depression

Contributed by Murdis Latoya Boston, MFTI, Department of Mental Health, SA 4

**Clinical depression is more than life’s “ups” and “downs”.** Life is full of joy and pain, happiness and sorrow. It is normal to feel sad when a loved one dies, or when you are sick, going through a divorce, or having financial problems. But for some people the sadness does not go away or keeps coming back. If your “blues” last more than a few weeks or cause you to struggle with daily life, you may be suffering from clinical depression.

**Clinical depression is not a personal weakness,** gracelessness or faithlessness. It is a common, yet serious, medical illness. Clinical depression is a “whole-body” illness that affects your mood, thoughts, body and behavior. Without treatment, symptoms can last for weeks, months or years. Appropriate treatment, however, can help most people who have clinical depression.

**Clinical depression can affect anyone.** Anyone can experience clinical depression, regardless of race, gender, age, creed or income. Every year more than 19 million Americans suffer from some type of depressive illness. According to a Surgeon General report, African-Americans are over-represented in populations that are particularly at-risk for mental illness. Depression robs people of the enjoyment found in daily life and can even lead to suicide. A common myth about depression is that it is “normal” for certain people to feel depressed—older people, teenagers, new mothers, menopausal women or those with a chronic illness. The truth is that depression is not a normal part of life for any African-American, regardless of age or life situation. Unfortunately, depression has often been misdiagnosed in the African-American community.

**Myths about depression:** The myths and stigma that surround depression create needless pain and confusion, and can keep people from getting proper treatment. The following statements reflect some common misconceptions about African-Americans and depression: “*Why are you depressed? If our people could make it through slavery, we can make it through anything.*” “*When a black woman suffers from a mental disorder, the opinion is that she is weak. And weakness in black women is intolerable.*” “*You should take your troubles to Jesus, not some stranger/psychiatrist.*” The truth is that getting help is a sign of strength. People with depression can’t just “snap out of it.” Also, spiritual support can be an important part of healing, but the care of a qualified mental health professional is essential. And the earlier treatment begins, the more effective it can be. *Source: Surgeon General Report (2001, 2009)*

## Media Review: Out of Our Right Minds...

*OUT OF OUR RIGHT MINDS; TRAUMA, DEPRESSION AND THE BLACK WOMAN*, produced by Wildseed Films/Intelligent Media Group, will premiere at the PATOIS International Human Rights Film Festival on March 13, 2010. Directed by award-winning independent filmmaker/documentarian Stacey Muhammad, a native of New Orleans, this film explores depression and the overall feeling of sadness that plagues many black women in this society of all ages, social and economic backgrounds. Statistics regarding depression in African-American women are either non-existent or uncertain. Part of this confusion is because past published clinical

research on depression in African-American women has been scarce. This scarcity is, in part, due to the fact that African-American women may not seek treatment for their depression, may be misdiagnosed or may withdraw from treatment because their ethnic, cultural and/or gender needs have not been met. Although an alarming number of African-American women suffer from depression, bipolar disorder and a myriad of clinically specific mental conditions, this film seeks to connect the state of mental health amongst women of color to the lingering effects of Post Traumatic Slave Syndrome, a trauma experience that has been passed on from one generation to the next. Women and men from all walks of life speak openly and candidly about depression, mental illness, anxiety, self-esteem and the need to address a topic that continues to be taboo in the African American community. *Out of Our Right Minds* is part one of a series of films from Wildseed Films/Intelligent Media Group aimed at healing and restoring the black family. Only by confronting and exploring the tragic reality of Post Traumatic Slave Syndrome and how the combination of physical trauma, domestic abuse, social conditioning, racist media images and spiritual neglect has affected the mind, body, soul of women of color will individual and collective healing take place.

**COD Alert: Teen Drug Abuse** *Source: Teen Drug Abuse Website 2011*  
*Contributed by Lamont Bell, Substance Abuse Counselor, DMH TAY Division*

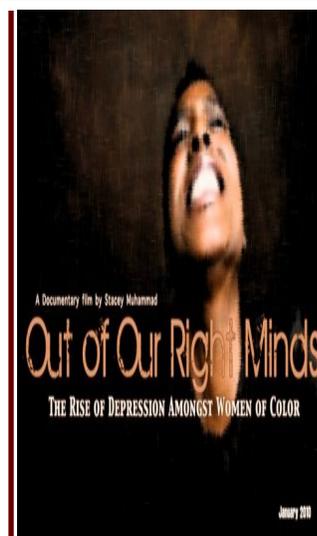
Teen drug abuse is a subject that has been receiving heavy media coverage recently. With the explosion of drugs such as ecstasy and meth on the scene, many teens find the temptation of experimentation with these drugs hard to resist. Teenagers may be involved with prescription drugs or illegal drugs in various ways. Experimentation with drugs during adolescence is common. Unfortunately, teenagers often don't see the link between their actions today and the consequences tomorrow. They also have a tendency to feel indestructible and immune to the problems that others experience. Using alcohol and tobacco as a teen increases the risk of using other drugs later. Some teens will experiment and stop, or continue to use occasionally without significant problems. Others will begin to abuse the drugs they once used only recreationally, moving on to more harmful drugs and causing significant harm to themselves and possibly others. Adolescence is a time for trying new things. A teen may abuse drugs for many reasons, including curiosity, because it feels good, to reduce stress, to feel grown up, and to fit in. It is difficult to know which teens will experiment and stop, and which will develop serious problems.

### *Drugs That Teens Are Abusing - Teen Drug Abuse*

- Prescription Drugs and Medications (such as Ritalin and Oxycontin).
- Inhalants: Known by such street names as huffing, sniffing and wanging. The dangerous habit of getting high by inhaling the fumes of common household products has claimed the lives of more than a thousand children each year.
- Many other young people, including some first-time users, are left with serious respiratory problems and permanent brain damage.
- Over-the-counter cough, cold, sleep, and diet medications (such as Coricidin).
- Marijuana: About one half of the people in the United States have used marijuana. Many are currently using it, and some will require treatment for marijuana abuse and dependence.
- Stimulants: The possible long-term effects include tolerance and dependence, violence and aggression. Crack, a powerfully addictive stimulant, is the term used for a form of cocaine that can be smoked.
- Club Drugs: This term refers to drugs being used by teens and young adults at all-night dance parties such as "raves" or "trances," dance clubs and bars

### *Signs & Symptoms of Teen Drug Abuse:*

- changes friends
- smell of alcohol or marijuana on breath or body
- unexplainable mood swings and behavior
- negative, argumentative, paranoid or confused, destructive, anxious
- overreacts to criticism, acts rebellious
- sharing few, if any, of their personal problems
- doesn't seem as happy as they used to be
- overly tired or hyperactive
- drastic weight loss or gain
- unhappy and depressed
- cheats, steals



### *Quote of the Month:*

*There is no greater agony than bearing an untold story inside you.*

*Maya Angelo*



## Feature Story:

### **African-American Gangs, Depression and Suicide**

**Source:** National Gang Crime Research Center (2008); Centers for Disease Control and Prevention



Information released by the National Gang Crime Research Center tells us that gangs have become a major social problem in communities nationwide. Gang violence, particularly assaults, drive-by shootings, homicides and brutal home invasion robberies account for one of the largest, single, personal threats to public safety. Gang members do crimes against people who are unable to defend themselves. They work in the darkness, from speeding cars or sneaking up on someone. The fear and personal tragedy inflicted by street gangs has touched millions of Americans whose children have been seduced by the glamour and availability of dangerous drugs and substances.

African-American gangs began forming in California during the 1920s. They were not territorial. Rather, they were loose associations, unorganized and rarely violent. They did not identify with graffiti, monikers or other gang characteristics. These early gangs consisted primarily of family members and neighborhood friends who were involved in limited criminal activities designed to perpetrate a "tough guy" image, and to provide an easy means of obtaining money. The Department of Justice estimates there could be as many as 65,000 African-American gang members in California today. The majority range in age from 12 to 35, with

some as old as 40. The gangs vary in size from 30 members to as many as 1,000. They continue to fight each other for narcotic-related profits and in defense of territory, and many remain unstructured and informal. A few of them are becoming organized with some definitive gang structure.

While some may find the gang culture history fascinating and worthy of historical relevance, others are most concerned with understanding some of the mental health implications and undisclosed stressors of the young African-American males who result to joining a gang as a means of coping with depression. "African-American adolescent boys underutilize mental health service due to stigma associated with depression," said Sean Joe, associate professor of social work and assistant professor of psychiatry at the University of Michigan. His research examines the epidemiology of suicide among African-Americans and father-focused, family-based interventions to prevent urban African-American adolescent males from engaging in self-destructive behaviors.

Black males are at particular risk. According to the Centers for Disease Control and Prevention, suicide is the third cause of death among African-American males between ages 15 and 24, behind homicide and accidents. Perhaps black males are in jeopardy because they bear the brunt of crime and drugs in the African-American community. According to some researchers, African-American males have a higher rate of joblessness, criminal victimization and incarceration than other segments of society. And although there is a stigma against suicide in the African-American community as a whole, suicide carries less of a stigma with young adults than with older blacks, Joe said. Of particular interest is the phenomenon of "suicide by cop" which is the luring in of a law enforcement official for the intent of provoking death by the law enforcement official.

Suicide by cop occurs more frequently than most people would imagine. In a study that was published in the *Annals of Emergency Medicine*, researchers analyzed data from the Los Angeles County Sheriff's Department. The researchers concluded that suicide by cop was surprisingly common and the number of incidents was rising.

Researchers studied data from 1987 through 1997 and found that 11-percent of officer-involved shootings were suicide by cop incidents. The results of the study, further extrapolated by Dr. Barry Perrou, forensic psychologist and former commander of the LA County Sheriff's Hostage Negotiations Unit, showed the following:-

- 98% were male
- Ages ranged from 18-54
- 58% had a psychiatric history
- 39% had a history of domestic violence
- 38% had a criminal history
- Many individuals abused alcohol and/or drugs
- Many individuals had a prior history of suicide attempts
- About 50% of the weapons used were loaded
- 17% used a toy or replica gun

Studies on law enforcement assisted-suicide continue around the U.S. Police departments are beginning to take notice of the long-range detrimental effects these dangerous incidents have on the police officers involved. In some cases, officers are placed in a no-win situation. The key to help unlock the secrets behind this phenomenon is in the sharing of information, training and raising awareness among police agencies. Recent changes in state laws regarding treatment of mentally ill individuals have increased the likelihood that law enforcement officers will encounter more of these incidents in the future. The dearth of adequate community-based services for this population leaves both the mentally ill and law enforcement vulnerable.



## MHSA/Prevention and Early Intervention

### TRANSITION AGE YOUTH DIVISION

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**Doralee Bridges**  
213-351-5225  
Dbridges@dmh.lacounty.gov

**Enhanced Emergency Shelter Program**  
**Sandra Sanchez**  
213-738-6194  
Ssanchez@dmh.lacounty.gov

### TAY Partners in Suicide Prevention Goals:

#### Educating

- Knowledge of practical strategies of dealing with suicide
- Understanding of suicidal ideation
- Knowledge to help identify those at risk and other risk factors
- Skills in how to help a person who is experiencing thoughts of suicide
- Learn about using intervention strategies in your community
- Learn basic strategies useful in detecting warning signs, listening and taking appropriate action

Empowering individuals and communities to seek the help they need

Enhance confidence in handling crisis situations

Resourcing ability to identify resources within your local community and effectively build a relationship with community mental health partners to address resource barriers and access to services

### Countywide Partners in Suicide Prevention Teams

Martha Alamillo	Tasha McFashion-Stiger	Anne Choe	Jae Won Kim
Children Youth and Family	Transition Age Youth Division	Adult Systems of Care	Older Adult Systems of Care
213-739-5412	213-351-7735	213-738-4140	213-738-4150
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### Survivor Support Groups

#### CALENDAR

##### February

\*Black History Month  
Workforce Education and  
Training (WET)  
Conference  
Southwest College  
February 15, 2011

Tool Kits for Working with  
African American Families  
Training Series  
Lancaster  
February 17, 2011

##### March

\*Social Work Month  
ASIST Workshop  
March 9th and 10th  
California Endowment Center

##### April

Available Dates for SEAT  
modules and Presentations  
Please Contact  
Tasha Stiger 213-351-7735

#### Encino

The Bereavement Counseling Center  
16255 Ventura Blvd Suite 308  
Encino, CA 91436  
Group Name: Survivors Personal  
Coaching Seminar  
Contact Person: Dr. Rosemarie White  
818-906-8832

#### Glendale

Glendale Adventist Medical Center  
Chaplain's Department  
1509 Wilson Terrace  
Glendale CA 91206  
Group Name: Mothers Surviving  
Suicide of a Child  
Contact Person: Alice Parsons Zulli  
818-409-8008

#### Culver City

Suicide Prevention Center  
Didi Hirsch Community Mental Health  
Center  
Group Name: Survivors After Suicide  
Contact Person: Rick Mogil  
310-895-2326  
310-391-1253 (24 hours)

#### Culver City

Group Name: Sibling Survivor  
Group  
Contact Person: Nancy Morrissey  
310-739-3349  
lilygardenalia@yahoo.com

#### Los Angeles

Survivors After Suicide  
2001 S. Barrington Ave #202  
Los Angeles CA 90025  
Group Name: Survivors After Sui-  
cide & Loss of A Child to Suicide  
Contact person: Terry Jordan,  
LCSW  
310-859-2241

#### West Los Angeles

Our House Grief Support Center  
1663 Sawtelle Blvd., Suite 300  
Los Angeles, CA 90025  
310-473-1511

#### Brentwood/ West LA

Compassionate Friends  
Chapter Name: Brentwood Santa  
Monica TCF Chapter  
Chapter Number: 1950  
jpbpr@aol.com

#### RESOURCES

TAY Division Email Address

[tay@dmh.lacounty.gov](mailto:tay@dmh.lacounty.gov)

DMH ACCESS Hotline

1-800-854-7771

National Suicide Prevention

Hotline

1-800-273-TALK (8255)

Didi Hirsch Suicide Prevention &  
Survivor Hotline

1-877-727-4747

TREVOR Helpline

1-866-4U-TREVOR

1-866-488-7386