Substance Abuse and Mental Health: Special Prevention Strategies Needed for Ethnics of Color

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POSITION STATEMENTS of the current Administration recognize the specific concerns of minorities in the fields of mental health, alcohol, and drug abuse prevention programs. This recognition is especially heartening to nonwhite minority groups. For example, the 1978 Policy Review on Drug Use Patterns, Consequences and the Federal Response devotes almost two pages to ethnic minorities, and the 1979 Federal Strategy for Drug Abuse and Drug Traffic Prevention cites planning and developing materials for ethnic minorities as a key element in prevention.

In a statement prepared for the Select Committee on Narcotics Abuse and Control Hearings of May 1979, Dr. Helen Nowlis described activities of the Office of Education that support programs tailored to the ethnic and demographic needs of communities. President Carter's 1978 message to Congress includes this statement: "Among some minority groups the incidence of addiction and the harm that it inflicts are disproportionate."

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The 1978 Report to the President from the President's Commission on Mental Health also reflects attention paid to America's ethnic and racial populations and the need for consideration of the various cultural traditions.

Thus, Government leaders are aware of the suffering of minorities caused by substance abuse and other elements, and they do support action to reduce the resulting harm. However, it is not possible to document the true extent of substance abuse and mental illness among minorities, as evidenced in the following statement of the Office of Drug Abuse Policy (*1*):

> Assessing the drug abuse problem in ethnic minority communities is a complex and difficult task, in part because of the lack of research information and data on the nature of the drug problems of such groups. . . . This has hampered efforts to make the drug programs and resources of the Federal Government available, accessible, sensitive and relevant to minority community concerns.

Why do the difficulties posed in this statement continue, given the resources of the Federal Government? To many minorities, the lack of data and resources may seem to be deliberate. So long as the incidence and prevalence of a maladaptive behavior remain unknown, substantial misconceptions can arise and resources can be misallocated. The Institute for Social Research at the University of Michigan, under a research grant from the National Institute on Drug Abuse, has published an ex-

tensive report on a survey of drug use, attitudes about drug use, and the perceived availability of drugs among high school seniors in 1977 (*2*). The following reasons for this survey are cited in the report.

—Accurate assessment of size and contours of the problem of illicit drug use among young Americans is important for public debate and policymaking.
—Reliable trend data permit assessment of the impact of major historical and policy induced events.
—Reliable trend data will help in early detection and localization of emerging problems.

Although these objectives are laudable and desirable for minority youth, the data presented were analyzed by sex, college plans, region of the country, and population density or urbanicity, but not ethnicity. I assume that ethnicity was omitted because the sample did not include large enough numbers of minorities to obtain a reliable assessment of the status of minority groups. Some data from the 1977 National Survey on Drug Abuse were presented in terms of whites and nonwhites (*3*). However, the data are of little value in determining the differences in drug usage within and between groups as well as the differences in the rankings of the perceived harm of drugs among the various groups. The aggregation of all ethnic groups into one statistic can be misleading because such a statistic can obscure the real differences among the groups, and it can lead to false inferences and counterproductive policies and actions.

Since minority populations are comparatively small and diversely distributed geographically, a larger sample than is commonly used in surveys is necessary to ensure adequate coverage of these populations. Although better and more timely statistical information is being increasingly provided for blacks and Hispanic Americans, the largest minority groups, few statistics are available in separate tabulations on groups such as American Indians, Chinese Americans, Japanese Americans, Mexican Americans, Cuban Americans, and Puerto Ricans.

Most of our knowledge of drug usage among minorities is based on data from institutions and social services—hospitals, coroner's offices, police agencies, and treatment programs; these data represent counts of various critical events related to drug use. The client oriented data acquisition process (CODAP) illustrates the tendency to obtain statistical information on clients admitted to treatment in federally funded clinics. The Drug Abuse Warning Network (DAWN) gathers drug abuse data from a sample of hospital emergency rooms, offices of medical examiners and county coroners, and crisis intervention centers. DAWN also typifies sources used for drug information about minorities. Rarely is information available on drug use among those of the minority populations who have little or no contact with institutions or agencies.

The distortions resulting from studies of data obtained from limited samples are readily apparent. For example, if the results of such studies indicate that heroin-related deaths and emergency room visits are at an all-time low, it may be concluded that the heroin problem in general is decreasing and therefore funds for addressing the problem will also be decreasing. However, since heroin addicts may have learned to avoid the institutions that provided the statistics originally, the "reduction" may be just an artifact of street wisdom.

Information on the extent of mental disorders by race is also unreliable. Kramer and associates (*4*) pointed out that adequate statistics are needed to plan programs geared to eliminate the attitudes, practices, and conditions of life that adversely affect the physical and mental health and social well-being of minorities and to allow evaluation of efforts to accomplish this goal.

This entire issue of factual information on minorities and mental disorders and abuse of drugs and alcohol was captured succinctly by Sue in a paper presented at the National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues (*5*). He stated:

First, in this stage of the status of ethnic minorities we need an increase in the quantity and quality of research studies. Because of methodological, conceptual, and practical problems in ethnic research we are still at the elementary steps in having systematic and accurate information on various ethnic groups. . . . We lack basic and essential information. For example, we still do not know how many Asians are in the U.S. Estimates vary from official sources to community leaders. The same situation exists for Mexican Americans. There is still a great deal of controversy over the rate and extent of mental disorders, drug abuse, and alcoholism among ethnic group individuals.

Although minority groups may not have an accurate count of drug use patterns as a result of missing or biased data, their concern for preventing drug abuse is as great as that of the majority group. Primary prevention strategies, in general, have had a rocky history and this is no less true of prevention activities generated by or for members of minority communities. The May 1979 issue of the *Monitor*, the house organ of the American Psychological Association, carries several articles that review some of the criticism provoked by the advocation of prevention. Although the focus is primary prevention of mental disorders, the same criticism applies to drug and alcohol abuse prevention. Key points made were:

—The time is not right for prevention as more research is needed on causal factors.
—Efforts to intervene with healthy people to reduce the incidence of disorders is Utopian nonsense.
—Is there a best way to deliver preventive services?
—Prevention is bad for the business of psychotherapists [and drug and alcohol treatment professionals].
—Where is the evidence that prevention makes a difference?

However, a most convincing argument for supporting

primary prevention is made in an editorial by Dr. George Albee in the same issue of the *Monitor*. Albee states:

> In view of the lessons of history and present reality, it is paradoxical that the bulk of current health care is directed at treatment rather than prevention. There has been dramatic improvement in the overall health of a majority of Americans during this century, but this improvement has been the result of successful prevention through better nutrition, pest and pollution control, vaccination and sanitation. . . .

The impetus that primary prevention is currently experiencing must be continued and advanced on both humanitarian and pragmatic grounds. Primary prevention models draw attention to the social context in which aberrant behaviors (mental disorders and drug and alcohol abuse) arise. Treatment allows the causal factors of such behavior to continue unmodified, to wreak damage over and over again.

Commonalities and Differences

The national policy of primary prevention of drug abuse postulated by NIDA stresses the relationship of drug abuse by young people to personal and social development. Further, the NIDA design neatly categorizes possible prevention programs as: information, education, alternatives, and intervention. Minority groups have no difficulty with this conceptualization and therein lies a commonality between the dominant and minority societies. Self-actualization is certainly highly prized and valued by nonwhite minorities, and the various categories identified by NIDA can and do provide avenues for the development of self-esteem—the raising of levels of aspiration. Nevertheless, the prevention model defined by NIDA does not embrace elements that are significant for these groups. One can infer from an analysis of the model that if steps are taken to promote personal and social growth, barriers to reaching full individual potential must be removed. However, this is simply not the case for minorities. A primary prevention drug abuse, alcohol abuse, or mental disorders program cannot be effective if policymakers fail to consider the contribution of prejudice and racial oppression to these problems.

In a report of the U.S. Commission on Civil Rights (*6*), indicators are presented for various aspects of education, employment, income, and housing for American Indians, Alaskan Natives, blacks, Mexican Americans, Japanese Americans, Chinese Americans, Filipino Americans, and Puerto Ricans. The social indicators clearly document many continuing and serious problems of inequality afflicting the groups studied. Some examples follow.

Delayed education. In 1976 the percentage of females and minority males 2 or more years behind the average school grade for their age was approximately twice the percentage for majority males. The education of most of the groups studied became relatively more delayed from 1970 to 1976, indicating increased inequality.

The minority group concern in the field of education is getting an education. The majority group seems to be concerned with truancy and runaways; minorities are concerned with pushouts, throw aways, or being classified as mental retardates.

High school nonattendance. Young people in some minority groups are at least twice as likely as majority males to be out of school at this important stage of their development.

The drug abuse professionals for the dominant society stress health curriculums or drug information that address drug issues in the school setting. For the minority communities, this approach allows a highly vulnerable and at-risk segment to remain untouched and ignorant of the consequences of drug abuse. A further note regarding the general effectiveness of information as a prevention strategy must be added. Myers' work (*7*) reveals that readily available and pertinent information about drugs has not been internalized among young minority persons. According to him, drug information materials are either written in standard English or Spanish, which may not be attended to or understood by young people from subcultures in which they are more adept at communicating orally than through the written word. Information materials also may be presented in audiovisual forms that exclude minorities and other low income groups (for example, "Reading, Writing, and Reefers"). If the gaps in drug knowledge are to be closed, drug abuse information must be presented in forms suitable to the interest and experiences of minorities and to which minorities can easily relate.

Housing. Minorities are more likely to live in central cities than the suburbs, less likely to be homeowners, more likely to live in overcrowded conditions, and more likely to spend more than a quarter of their family income on rent.

It has been found that within the majority culture there is a strong possibility that children may be introduced to drug use by older brothers or sisters. Given the housing conditions just described it is probable, even more likely, among minorities that behavior of older siblings will be witnessed by and thus copied by younger children.

Income and poverty. Minorities are more likely to be unemployed (especially the teenagers), to have less prestigious occupations, and to be concentrated in occupations that are different from those of majority males. With regard to income, minorities have less per capita

household income; lower earnings even after such determinants of earnings as education, weeks of work, age, and occupation status have been adjusted for; smaller annual increases in earnings with age; and a greater likelihood of being in poverty.

Persons experiencing these conditions are likely to feel frustration, pain, powerlessness, lack of hope for change, and alienation. All of these feelings have been identified as correlates of substance abuse activity—using substances to escape or dilute such feelings.

Similar conclusions were reached by the Task Panel on Special Populations of the President's Commission on Mental Health (*8*). This Panel's views indicate the important linkage between psychosocial factors and healthy development.

The primary avenue to reduction in prevalence and incidence of mental disorders in the Black (minority) community is not professional services to individuals but changes in society at multiple levels. Data suggest that a certain level of income, housing, employment, educational opportunity, health care, for example, are requisite conditions to the prevention and maintenance of optimism, positive self-esteem, and general mental health. Blacks (minorities) face specific problems at every point in the life cycle so that the greatest promise is in prevention programs keyed to needs at each phase.

Prevention Strategies

Implicit in the preceding section have been ethnic concerns about national prevention policies and programs. One concern needs specific highlighting—it stems from the Institute's interpretation of the Federal Government's need for measures of the cost effectiveness of funded activities. It is the concern of minorities with prescribed impact measures or evaluation of programs. Too frequently, program evaluation has meant a loss of program funding for minorities, not because goals and objectives were not met but because results were not expressed in terms of statistical significance or levels of confidence. For example, a program manager of a drug prevention project indicated that she made use of tape-recorded sessions to document attitudinal changes and was told that this was not sufficient for measuring program impact.

Congress has a need to know that taxpayers' dollars are being spent wisely and for worthwhile causes. Our policymakers, however, are reasonable men and women. There are ways to document outcomes and program results that do not require use of an experimental design or control groups or random sampling that would be acceptable, it is believed, to the Congress.

The senior level managers who award grants and contracts should be satisfied with evidence that the programs are doing what they originally claimed they would do. Sometimes this evidence may come from taped interviews of participants or relatives of participants. The evidence could be as simple as attendance records of recipients in a particular activity. The application of sophisticated statistical procedures does not make a good program better or a bad program worse. In many instances, prescribed evaluative techniques are simply one more obstacle to provision of services to minorities.

At a recent workshop held in the District of Columbia for minority managers of drug abuse prevention programs this latter perception was voiced most frequently. In essence, members were saying that they had been encouraged by getting program funds; pleased at having learned how to write proposals in language acceptable to funding agencies; and satisfied with the progress being made and the goals and objectives achieved. Then when they felt they had mastered the twists and turns of the funding maze, the rules were changed. Now, programs would be funded only if an evaluation component were included. The evaluation component would be judged, it seemed, on the basis of level of sophistication. Never mind that service delivery would be interrupted, if not terminated. No matter that clients would be lost for lack of a regression equation—a coefficient of reliability. To receive funds, it seemed, it was necessary to administer the Minnesota Multiphasic Personality Inventory (MMPI) to Native Americans, Mexican Americans, Asian Americans, blacks, and Puerto Ricans in pre- and post-test designs. To provide services, the criterion of need is second to the criterion of using an identified, reliable, and valid instrument. The intuitive rejection of prescribed evaluation strategies by minorities gains a measure of support from recent published statements of "experts" or "scholars."

Schulberg and Perloff (*9*) took a look at the state of evaluators of human service delivery programs. Some of their findings were:

—The traditional source for program evaluators has been academically educated researchers who have learned to use experimental techniques and statistical analyses to investigate theoretical issues but rarely have acquired skills needed for improving service delivery.
—Evaluators trained in experimental design, when required to assess services and suggest policy directions, may use methodologies and instruments better suited to controlled laboratories than a chaotic organization.
—Untrained researchers faced with assessment of services may derive unwarranted conclusions from studies possessing neither internal nor external validity.
—Most graduate programs use the research or clinical training models, neither of which is directly relevant to evaluation training.
—Few academicians appreciate the conceptual and methodological differences between generating new knowledge and evaluating existing programs and innovations.
—Evaluators must recognize the practical and conceptual implications of choosing among the amelioration, accountability, and advocacy program evaluation models and the ethical dilemmas contained in each.
—Gathering data for program-specific decisions and for broad

issues may require a variety of evaluative designs; e.g., case studies, quasi-experimental, legal adversarial approaches, etc.

The following quote very accurately reflects the conclusions of minorities (*10*):

> Sound scientific study refers to the *logic* of design, observation/measurement, analysis and interpretation. But we must avoid the mistake of assuming that if a research tool is complicated, quantitative and esoteric it therefore must be sound. You buy complexity, quantification and precision at a cost in constraining assumptions, limits to generalizability and increases in artificiality.

Just as minorities know the burden of oppression and racial discrimination without the assistance of measuring tools or evaluative research, they are also aware when this burden has been lessened, for example, the growth in self-esteem that comes with getting a job—knowing that one's voice is heard. One's ability to make demands may not be reflected on the Tennessee Self Concept Scale (which is irrelevant anyway to the person who has discovered inherent strengths and ability).

The psychosocial stresses for minorities are blatantly apparent, and program strategies must be directed toward alleviating these stresses. If it can be demonstrated that a program results in keeping children in schools, in day care centers so that parents can work, or in their homes rather than with foster care parents or in institutions; that program activities provide young people with marketable skills, appreciation of their unique culture, value systems, beliefs, and recognition and respect for survivial skills—street smartness—then such programs would be viewed from the multicultural perspective as primary prevention.

Evaluation strategies must be considered within the context prescribed by Bush and Gordon (*11*):

> We have to decide in each particular case not only whose view more closely represents the situation but also who will be most affected by whatever service decision is made. The professional (evaluation specialist) who prevails over a client (program manager) for reasons no other than his/her possession of well tested knowledge has won an encounter for one version of the truth or less dramatically, for the professionals' right not to be unduly challenged or inconvenienced. The client who loses such a battle will have lost things the client considered vital to his/her well being.

In short, the professionally trained researcher has learned to appreciate a special way of defining truth. If a program manager disagrees with the researcher's perception of truth, human wastage may result.

This is not an argument to do away with evaluation; rather, it is a plea for appropriate recognition of the complexity of the primary prevention concept. As Caplan and Grunebaum point out, the goals of prevention efforts are rarely single and simple; usually, they are multiple and complex (*12*). Specifying and obtaining adequate controls are also difficult. What may seem to be objective data may depend on unseen and unstudied subjective factors of both the recipients and their families, as well as of professionals. Caplan and Grunebaum acknowledge that different methods of evaluation will be appropriate for different programs. In some cases, subjective reports by clients of increased self-confidence or decreased familial discord will be appropriate; in other cases, clinical judgment of the extent of personal growth and development or professional assessment of increase in IQ; and for still others, lowered rates of homicide. To reiterate, from a multicultural perspective, counts of the numbers of adolescents who have secured employment or the numbers of eligible families who have been taught how to obtain food stamps are valid indicators of the efficacy of primary prevention programing.

I hold that political-social factors, rather than the individual minority member, are the primary foci for prevention programs. Equipping minorities with the wherewithal to maneuver successfully through a system that constantly rebuffs them is a germane goal for primary prevention programs.

Finally, awareness of ethnic minorities' concerns in primary prevention can be drawn from previous conferences, workshops, task force meetings, and the like. In reading the proceedings, one finds certain themes repeated. Prevention issues are an example.

Prevention Issues

Prevention, a service intervention strategy that has the potential for improving the health of all people in our society, has not been sufficiently supported by policy or funding. Racial minorities in particular are especially in need of additional community-based prevention programs. At the 1978 Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues, held in Denver, the following recommendations were made (*13*):

1. The Alcohol, Drug, and Mental Health Administration (ADAMHA) develop a comprehensive list of racial minority prevention specialists to include: consultants, researchers, practitioners, and advisors who could contribute to the prevention strategy of ADAMHA.
2. ADAMHA and its Institutes immediately promote racial minority prevention programs which would:
   a. Develop preventive strategies relevant to socio-cultural factors for implementation by state, county, and local mental health programs;
   b. Develop prevention materials relevant to each particular racial minority community, appropriately designed in the languages and "dialects" of the various monolingual and bilingual racial minority communities.
   c. Develop training programs in prevention for treatment personnel based upon the conceptual theory and practical skills relevant to racial minority and socio-economically oppressed people; and
   d. Develop specific "coping/survival" skill curricula applicable to each racial minority group in primary and secondary education levels.
3. ADAMHA provide the Minority Advisory Committee with a report on the current status of ADAMHA's efforts to ensure relevant prevention for racial minorities.

4. ADAMHA initiate the drafting of legislation which would require ten percent of Community Mental Health Center (CMHC) funds to be utilized for primary prevention programs and public health strategies.

ADAMHA has made available its "Final Progress Report" on the implementation of the formulated recommendations (*13*). The document details ADAMHA's effort to respond to the concerns expressed by the conference participants. Some of the recommendations have been completely implemented and others have been only partially implemented owing to conflicting priorities, lack of resources, or lack of authority to act.

A recent issue of the ADAMHA News quotes the ADAMHA administrator as stating that "the mental health field should confine its intervention to activities based on accepted concepts of public health, scientific evidence, and the profession's social mandate to perform specialized tasks" (*14*). Changing the societal context in which minorities live is clearly beyond the province of mental health services and providers. Advocacy within the mental health field, however, can lead the way toward improving the quality of the social milieu. An effective multicultural approach to prevention of drug abuse, alcohol abuse, and mental illness must incorporate the recommendations made to the President's Commission on Mental Health by the Special Populations Subpanels on Health of Black Americans (*8*):

1. Full employment achieved through the initiatives of the public and private sectors, and equal access to jobs assured by the continuation of affirmative action legislation.
2. Affirmative action in the distribution of housing funds and opportunities for adequate housing.
3. Redistribution of health care facilities, with particular attention to primary prevention, and (2) improving access to quality health care.
4. Implementation of public welfare services that concentrate on the elimination of poverty and which support and supplement the initiatives of individuals to be participants in American society.
5. Lack of professional health and social manpower is a serious problem for minorities. Strong emphasis must be placed on manpower and scholarship programs for minorities so that they can assume responsibilities for their own destiny.

Comments

In this paper I have tried to underscore the work that needs to be done to address the alcohol, drug abuse, and mental health concerns of ethnic minorities. It would benefit minorities if relevant statistics were gathered and reported with respect to trends, attitudes, and drug use patterns of our young people. We need to know, for example, at what particular age our youngsters are most likely to begin experimenting with chemicals and which chemicals are most likely to be abused.

I believe that programs for preventing drug abuse, alcohol abuse, and mental illnesses among minorities must continue to be funded at levels that will support meaningful efforts. Additionally, evaluative measures must reflect an understanding of the status of ethnic minorities. Research that focuses primarily on characteristics of the individual person rather than on the social, psychological, and physical milieu in which the individual functions may result in distorted data. I argue for evaluation studies of situational factors, such as increases in the numbers of day care centers, job training opportunities, voter registration drives, and the like. Measures of self-esteem, decision-making abilities, and other person-centered traits imply that the aberrant behavior is the fault of the individual. Ethnics of color believe such behavior is too often caused by the political-social system that confronts us daily.

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