Public–Academic Linkages for Culturally Sensitive Community Mental Health

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ABSTRACT: This paper traces the sixteen year history of a unique community mental health center which has combined academic and service provider roles in delivery of culturally appropriate care. Initially an arm of a department of psychiatry and derived from an anthropological research project, the center model was based on seven teams serving discrete ethnic communities, with subsequent development of a network of neighborhood-based “mini-clinics” as well as centralized aftercare facilities. The team staff—social scientists, clinicians, and paraprofessionals all of matching ethnicity to the populations served—became a core of “culture brokers” with a service, teaching, and research role at the interface of the university, medical center, and community. Subsequently the university was funded for a cross-cultural training institute for mental health professionals. Center staff extended training in culturally appropriate care to 174 mental health professionals from 97 facilities throughout the nation, as well as other spinoffs improving cultural expertise of staff in public sector agencies. Data on effectiveness of services and training are given and significant findings are discussed. The description includes the impact of historical shifts in funding, the effects of external events on community mental health center structure, and the current state of cross-cultural training and public-academic linkages in this particular program.

Public-academic linkages have always been desirable from both a service and training viewpoint. The need for well-trained practitioners in public service delivery, particularly in work with seriously mentally

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ill persons, is matched by the need of universities to provide educators who are well-versed in state-of-the-art theory, research, and practice. One of the best ways to accomplish this is for universities and public sector agencies to promote bridging positions for academicians in public sector service delivery.

Currently there is a multidisciplinary focus on training clinicians to serve seriously mentally ill persons (Cutler & Lefley, 1988; Faulkner et al., 1980; Lefley, Bernheim & Goldman, 1989). National Institute of Mental Health (NIMH) initiatives simultaneously emphasize serving minority populations, of whatever types or levels of psychopathology, in a "culturally sensitive" way. The extent to which various minority groups are represented in the seriously mentally ill population is variable and difficult to assess (Lefley, 1990; Snowden & Cheung, 1990). According to the latest national data base, American Indians and Blacks are admitted to all inpatient psychiatric services at rates over three times higher than those of Asians, about twice higher than Hispanics, and about one and one half times higher than Whites. In public sector state and county mental hospitals, American Indians and Blacks are admitted at rates four times greater than Asians, two to two and one-half times more than Hispanics, and two and one-quarter to two and two-thirds more than Whites. In all inpatient admissions, the order from highest to lowest is Blacks, American Indians, Whites, Hispanics, and Asians, although Hispanics are somewhat higher than Whites in state and county hospital admissions. Yet, in state and county mental hospitals, Asians, Hispanics, and Whites, in that order, have higher median inpatient stays than do Black or American Indian patients (Rosenstein, Milazzo-Sayre, MacAskill, & Manderscheid, 1987). Manderscheid (personal communication) indicates that by next year we should have a more precise count on ethnic distribution and other characteristics of persons with serious and persistent mental illnesses through the NIMH mental health supplement to the National Health Interview Survey.

Meanwhile, the variable picture shown in the above data suggests a range of possible differences in ethnic communities. These may include legitimate differences in prevalence and intensity of major types of psychopathology which require hospitalization. Alternatively, they may reflect variation in cultural belief systems, symptom thresholds, supportive networks, community stigma and tolerance levels, differential access to mental health systems and use of traditional healers, discrete patterns of stressors, and other socioeconomic and cultural variables affecting the developmental stage of presentation for services