

# “Depression in Kansas City”

What’s being done and what is needed.

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A report by the Metropolitan Health Council

Funded by the Prime Health Foundation

# Report Contents

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<b>Executive Summary</b> .....	<b>1</b>
<b>Introduction</b> .....	<b>7</b>
<b>Section I: Overview</b> .....	<b>9</b>
<b>Section II: Depression Prevalence</b> .....	<b>10</b>
<b>Section III: Suicide</b> .....	<b>16</b>
<b>Section IV: Treatment for Depression</b> .....	<b>21</b>
<b>Section V: Efforts in Kansas City to Address Depression</b> .....	<b>28</b>
<b>Section VI: Upcoming Activities Resulting from Metropolitan Health Council Recommendations</b> .....	<b>34</b>
<b>Section VII: Conclusion</b> .....	<b>36</b>
<b>Endnotes</b> .....	<b>37</b>



# Executive Summary

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Kansas City is at the forefront of American cities in launching major initiatives to improve the community's ability to prevent and respond to depression among its residents. At the same time, these efforts have increased our awareness of the need to do more and to more fully understand the issues related to depression among various members of our community.

At the urging of members of various affected populations, and of health and mental health care providers, the Metropolitan Health Council undertook a review of the problem of depression in our community and prepared this report. (The Metropolitan Health Council is a non-partisan group, brought together by Prime Health Foundation, dedicated to facilitating community responses to health problems in the Kansas City metropolitan area.)

This report discusses the magnitude of the problem of depression nationally and locally and looks at depression among particular groups of individuals in our community, highlighting specific issues they face. These groups are a) the elderly; b) certain minority populations (African Americans, Hispanics, Native Americans); c) gays and lesbians; d) pregnant and postpartum women; and e) youth. It also describes the initiatives that are underway in the Kansas City area to address depression. The report concludes with discussion of a new initiative aimed at increasing skills and capabilities within the faith community (clergy and lay members) so they are better able to identify and respond to depression among congregants.

To highlight some of the information contained in the report:

- ◆ It is estimated that, in any year, more than 50,000 adult residents of the five-county metropolitan Kansas City area suffer from clinical depression. This includes an estimated 17,500 adult men and 38,000 adult women residents. (The

five counties in the metro KC area are Jackson, Clay, and Platte counties in Missouri and Johnson and Wyandotte counties in Kansas.)

- ◆ Among youth ages 10-19 in the five-county Kansas City area, it is estimated that approximately 27,200 in our community suffer from depression. This may be conservative. A recent survey of 30 freshmen and sophomore students in a high school in the Kansas City area found that 50% self reported experiencing debilitating depression in the previous year.
  
- ◆ A recent survey of gay, lesbian and bisexual residents of the metropolitan Kansas City area found that among gay respondents, 30% reported that depression negatively affects their normal activities. Among lesbians this was 31%, and among bisexual survey respondents, 42% indicated that depression negatively affects their normal activities.
  
- ◆ Studies have shown that many suicidal individuals are significantly depressed. Over a ten-year period there are more than 2,000 suicides among residents of the five counties in the metropolitan Kansas City area. A study that compared Kansas City with other areas in the U.S. found that the greater Kansas City area experiences a slightly higher suicide rate than the nation as a whole and than most states and comparable communities.
  
- ◆ In 2003, among Missouri students grades 9-12, more than one in five girls and more than one in ten boys indicated that they had seriously considered attempting suicide during the previous 12 months. Of these, 7.3% indicated that they actually attempted suicide one or more times during the previous 12 months (9.8% of girls – nearly one in ten – and 4.8% of boys). In 2003, among Kansas students grades 9-12, 17.8% indicated that they had ever seriously considered attempting suicide. Of these, 6.1% indicated that they actually had attempted suicide one or more times in the previous 12 months.

- ◆ Though treatment can alleviate depression for 80% of those suffering from depression, nationally, fewer than one in four adults diagnosed with depression receives treatment. Even fewer African Americans and Hispanics diagnosed with depression receive treatment

Among the notable initiatives discussed in the report that are underway to study and/or address depression in Kansas City are these:

- ◆ **KCQIC's Depression Guidelines**

The Kansas City Quality Improvement Coalition (KCQIC), a collaborative of local medical societies and health care organizations sponsored by the UAW-Ford Community Health Care Initiative, has developed and distributed to area primary care physicians "best practice" guidelines on management of depression. Kansas City is the only place in the nation where all major health plans and medical organizations have participated in developing common sets of clinical guidelines that are then distributed to their participating/member primary care physicians.

- ◆ **Mid-America Coalition on Health Care's Community Initiative on Depression**

In 1998, the Mid-America Coalition on Health Care (MACHC) embarked on a project with a number of major Kansas City area employers to identify the leading health risks in their employed population and their dependents. A consensus was reached by the participating employers to focus their efforts on the human and financial costs of depression – one of the most prevalent and undiagnosed diseases in the workplace and community. MACHC's resulting Community Initiative on Depression has as its broad objectives to de-stigmatize depression, identify the direct and indirect costs of depression, and to create a community infrastructure to support appropriate detection of depression, diagnosis, treatment and adherence to treatment. The Initiative boasts many work place and provider community accomplishments and has received national attention for its groundbreaking nature.

♦ **Kansas City Lesbian, Gay, Bisexual, and Transgendered  
Community Health Assessment**

In 2003, the Kansas City Health Department joined with the Lesbian and Gay Community Center of Greater Kansas City in developing and administering a survey to nearly 1,500 gay, lesbian, and bisexual men and women in our community in order to learn more about health and social issues affecting them. As reported in the Kansas City Star, this survey “is one of the few attempts [nationwide] to gain a thorough understanding of a gay community’s health, and it’s already being applauded by national experts.” A substantial finding relates to the degree to which these groups experience feelings of depression, as noted earlier.

♦ ***Cultural Competency and Mental Health in the Hispanic  
Community of Jackson County, Missouri***

Released in June, 2003, this, too, is a landmark report. The report was prepared by the Mattie Rhodes Center, an organization that offers bilingual (Spanish and English) social services, mental health, counseling, and art experiences, primarily to Latinos in our community. The report aims to improve knowledge among area civic leaders, public officials, social service providers, and others, about cultural competency and mental health issues. Sections of the report examine depression in the Latino community and barriers to care.

♦ **Mental Health Association of the Heartland (MHAH)**

This bistate advocacy, education, and support organization with offices in Kansas City, Kansas, aims to promote the mental health of the community. Efforts of particular note include a) a publication called *In the Company of Others: 2002 Kansas City Self-Help & Support Group Directory*; b) educational programs on postpartum depression; c) educational programs for the clergy on depression; and d) sponsorship of a teen suicide prevention program. MHAH is also designated as an outreach

partner of the National Institute of Mental Health and, as such, has available copies of NIMH's many brochures and booklets covering various facets of mental health/illness including depression.

#### ◆ **Teen Suicide Initiatives**

In the Kansas City area, interest has been high in the mental health, school and law enforcement communities in addressing teen suicide. Efforts on the Missouri side include the Safe Passages program looking at teen violence, of which teen suicide is a piece. Several of the Caring Communities sites are working on the issue as it relates to their individual site needs; and some community mental health centers have programs addressing teen violence and suicide. On the Kansas side, a broad-based coalition organized in 1998 by law enforcement officers in Overland Park has been working on the issue. The aim of this effort is to increase public awareness of teen suicide through classroom presentations and workshops for students and teachers in Johnson and Wyandotte Counties. The program also sponsors a teen suicide helpline.

#### ◆ **Primary Care/Mental Health Integration Modeling**

Studies have shown that, while 30% to 50% of primary care patients have anxiety or depressive disorders, primary care clinicians underdiagnose depressive disorder. In response, new models are being developed that strive to integrate into the primary care setting the delivery of specialty mental health services. These new models of service delivery include consultation-liaison models (mental health specialist is called in as a consultant at request of PCP) and integration of mental health professionals into primary care. Locally, Tri-County Mental Services, Swope Health Services, and Truman Medical Center have developed unique integration service delivery models.

#### ◆Proposed Faith Community Initiative

As the Metropolitan Health Council reviewed the many activities taking place in greater Kansas City to address depression, an area identified as “not yet owned” by any group and in need of attention was a program to enhance the ability of faith communities to respond to depression among their congregants. A local survey of area employees found that many people suffering from depression turn to prayer or otherwise seek assistance through their religious or spiritual community. Other studies across the country have reported similar findings. The Center for Practical Bioethics and the Mental Health Association of the Heartland are seeking funding for a two-year Compassion Sabbath of Hope for Depression campaign aimed at improving the response of faith communities to depression among their congregants.

# Introduction

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Kansas City is at the forefront of American cities in launching major initiatives to improve the community's ability to prevent and respond to depression among its residents. At the same time, these efforts have increased our awareness of the need to do more and to more fully understand the issues related to depression among various members of our community.

At the urging of members of various affected populations, and of health and mental health care providers, the Metropolitan Health Council<sup>1</sup> undertook a review of the problem of depression in our community and prepared this report.

The report discusses the magnitude of the problem of depression nationally and locally and looks at depression among particular groups of individuals in our community, highlighting specific issues they face. These groups are:

- ◆the elderly
- ◆certain minority populations (African Americans, Hispanics, Native Americans)
- ◆gays and lesbians
- ◆pregnant and postpartum women
- ◆youth

It also describes the initiatives that are underway in the Kansas City area to address depression. The report concludes with discussion of the need for a new initiative aimed at increasing skills and capabilities within the faith community (clergy and lay members) so they are better able to identify and respond to depression among congregants.

The depression report concludes with a summary of its main points:

1. Depression is a profound problem in our community given its scope, how it affects people's quality of life, and its economic impact.
2. Depression is diagnosable and treatable.
3. Efforts in our community aimed at addressing depression and the stigma surrounding it are to be commended and need to continue.
4. Additional training is needed to support those in faith communities to whom depressed persons turn for help.

## Section I: Overview

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At some time or another, almost everyone will experience a tragic or unexpected loss or a serious setback and times of profound sadness, grief, or distress. Major depressive disorder, however, differs both *quantitatively* and *qualitatively* from normal sadness or grief.

Normal sadness and grief are typically less pervasive and generally more time-limited. Moreover, some of the symptoms of severe depression, such as the inability to experience pleasure, hopelessness, and loss of the ability to feel a mood uplift in response to something positive, only rarely accompany normal sadness. Suicidal thoughts frequently signify a pathological state of major depression.

Depression disrupts the lives of depressed persons and their families.

**Major depression is the leading cause of disability and is associated with about half of all suicides.<sup>2</sup> With respect to suicides among children and adolescents, the Surgeon General estimates that more than 90% of children and adolescents who take their lives had a mental health disorder such as depression.<sup>3</sup> In the workplace, depression is a leading cause of absenteeism and diminished productivity.**

**Major depressive disorder, however, differs both *quantitatively* and *qualitatively* from normal sadness or grief.**

The impact of depression on overall health and productivity is often profoundly under-recognized.<sup>4</sup>

**Depression's deleterious impact on the American workplace was estimated to be \$43 billion in 1990, with absenteeism alone contributing \$12 billion.<sup>5</sup>**

## Section II: Depression Prevalence

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Approximately 20% of the U.S. population is affected by mental illness during a given year. Of all mental illnesses, depression is the most common disorder.

More than 19 million adults in the U.S. suffer from depression. In any year, about 6.5% of women, and 3.3% of men will have major depression.<sup>6</sup>

**Applying national rates of depression to U.S. Census Bureau population numbers for 2000, it is estimated that in the five counties of metropolitan Kansas City,<sup>7</sup> more than 17,500 adult men (18 years of age and older) and 38,000 adult women (18 years of age and older) suffered from clinical depression in that year.**

Major depression is not limited to adults. Depression affects as many as one in 33 children and one in eight adolescents.<sup>8</sup> In fact, depressive symptoms have been recognized even among infants.<sup>9</sup> Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.<sup>10</sup>

**Of all mental illnesses, depression is the most common disorder.**

**Applying the national estimate that one in eight adolescents suffers from depression to census numbers for youth 10-19 in the five-county Kansas City area, suggests that approximately 27,200 teens in our community suffer from depression. This may be conservative. A recent survey of 30 freshmen and sophomore students in a high school in the Kansas City area found that 50% self reported experiencing debilitating depression in the previous year.<sup>11</sup>**

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### **Populations with High Rates of Depression<sup>12</sup>**

Serious mental illness can occur across the lifespan, affecting persons of all ages, all racial and ethnic groups, both sexes, and all educational and income levels. With respect to depression in particular:

- ◆Major depression affects approximately twice as many women as men.
  - ◆Women who are poor, on welfare, less educated, unemployed, and from minority populations are more likely to experience depression.
  - ◆Adults and older adults have the highest rates of depression.
- 

### **Depression in Specific Populations**

Populations that were the focus of the Metropolitan Health Council's review are a) the elderly; b) certain minority populations (African Americans, Hispanics, Native Americans); c) gays and lesbians; d) postpartum women; and e) youth.

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### **Older Adults and Depression<sup>13</sup>**

- ◆Eight to 20% of older adults in the community<sup>14</sup> and up to 37% of older adults in primary care settings experience symptoms of depression (also called "minor depression" which does not meet the criteria for a DSM IV diagnosis of major depression but is more frequent than major depression). [Note: Both major and minor depression are associated with significant disability in physical, social, and role function. Both are also associated with high health care utilization and poor quality of life.]<sup>15</sup>
- ◆Best estimate 1-year prevalence rates for persons 55+ are 3.8% for Major Depressive Episode and 3.7% for Unipolar Major Depression.<sup>16</sup>
- ◆The prevalence of major depression declines with age, while depressive symptoms (minor depression) increase, especially among women.<sup>17</sup>
- ◆Depression rates are higher among older adults with coexisting medical conditions. For example, 12% of older persons

hospitalized for problems such as hip fracture or heart disease are diagnosed with depression.

- ◆ Among older persons in nursing homes, approximately half are at risk for depression with actual rates ranging from 15 to 25%.<sup>18</sup>

(See also information on older adults and suicide in next section.)

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### **Minority Populations and Depression**

National surveys have found differences in prevalence rates, risk factors, and symptoms for different ethnic groups.<sup>19</sup> The first large-scale probabilistic study<sup>20</sup> of psychiatric epidemiology, conducted in 1988, found the lifetime prevalence of major depression was 4.8% for whites, 2.9% for African Americans, 4.3% for Latinos, and 3.4% for Asian Americans. Although prevalence was slightly higher for whites than for Latinos and Asians, the differences were not significant. But the prevalence rates differed significantly between African Americans and whites, suggesting that African Americans were less likely than whites to report depression. A later study reported in 1994<sup>21</sup> found much higher lifetime prevalence rates for whites, at 17.9%; African Americans, at 11.9%; and Latinos, at 17.7%. This confirmed what other studies have shown, that prevalence rates for major depression are increasing. At the same time, the rates in this study were arrayed similarly to the earlier study, with the rate for African Americans significantly below those of whites and Latinos. (Neither of the two national surveys included depression prevalence estimates for Native Americans.)

An interesting finding from other studies<sup>22</sup> of Mexican American immigrants is that more recent immigrants had better mental health outcomes than more acculturated immigrants. One theory to explain this finding is that immigrants may develop feelings of self-depreciation and isolation from the traditional support systems as they assimilate to the dominant culture.

Unfortunately, information allowing a full understanding of the prevalence of depression among members of various racial and ethnic

**Most research on depression conducted in the United States has focused on the white population.**

minority populations is woefully lacking. Whites are over represented in national epidemiological studies, and most research on depression conducted in the United States has focused on the white population.<sup>23</sup> For example, a literature review<sup>24</sup> yielded only two articles that evaluated depression in Native Americans – one based on a sample of 120 adults of residents of a coastal Indian village in Washington state and the other studying 100 adult outpatients of a primary care clinic at the Albuquerque Indian hospital.

While the inclusion of ethnicity and race as variables in the epidemiological research regarding depression has been increasing, there are problems with the use of ethnicity and race in research.<sup>25</sup> Among these are the heterogeneity of the population to be studied as an ethnic group – for example, the ethnic group “Latinos” might include populations as diverse as Cubans, Mexican Americans, and Puerto Ricans – and the ethnocentric bias<sup>26</sup> that affects the interpretation of the data. Despite these challenges, in the studies, it is clear that ethnicity and race influence the incidence of depressive disorders.

Two risk factors for depressive symptoms are common in ethnic minority groups: racism and discrimination. Further, the history of each ethnic group in this country gives clues to its experience of depression. As examples, the historical subordination of African Americans through slavery and the uprooting and relocation of Native Americans to reservations, and the removal of their children from their homes to send them to white-run boarding schools (a practice that continued until the middle of the last century), must contribute to feelings of alienation and defeat, precursors for depression.

(See also information on Native Americans and suicide in next section.)

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### **Gay and Lesbians and Depression**

A recent survey<sup>27</sup> by the Kansas City Health Department and the Lesbian and Gay Community Center of Greater Kansas City found that among gays, 30%<sup>28</sup> of respondents reported that depression negatively affects their normal activities. Among lesbians 31%

**reported that depression negatively affects their normal activities.<sup>29</sup> Among bisexual survey respondents, 42% reported that depression negatively affects their normal activities.<sup>30, 31</sup>**

Fewer than one in four gays and lesbians, and fewer than one in five bisexuals, responded “never” when asked how often depression negatively affects their normal activities.

Remarkably, though the sample size of lesbian respondents ages 16-19 was small (N=24), 53% indicated that depression “always or very often” affects their normal activities.<sup>32</sup>

Fortunately, local data are available since no federal surveys of mental health and mental disorders currently ask sexual orientation and gender identity questions.<sup>33</sup> The nationally-administered Behavioral Risk Factor Surveillance Survey does include a module that asks questions regarding sexual orientation, but it is an optional module to supplement the core questions and the module has not been asked in any reported survey.

(See also information on gay and lesbian adults and youths and suicide in next section.)

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### **Perinatal Depression**

Historically, pregnancy was considered protective for depression. Recent studies, however, indicate that the rates of major depression during pregnancy and after giving birth are similar to rates in non-childbearing women (10%-15%).<sup>34</sup> In addition, one study found that symptoms of psychological distress often increase during the second and third trimesters of pregnancy.<sup>35</sup>

Since 3.5 million women give birth every year in the United States, this would mean that between 350,000 and 525,000 women will suffer from major depression before or after giving birth. Among these are women from all racial, educational, and income groups.

Risk Factors for perinatal depression<sup>36</sup> include:

- ◆ Previous episode of perinatal depression or anxiety (50-80% chance of reoccurrence)
- ◆ Personal or family history of mental illness (especially depression)
- ◆ Poor support system
- ◆ History of severe PMS or Premenstrual Dysphoric Disorder (PMD)
- ◆ Traumatic birth experience
- ◆ Perinatal death
- ◆ Advanced maternal age
- ◆ History of sexual abuse or victim of sexual assault
- ◆ Thyroid dysfunction
- ◆ Chronic sleep deprivation and fatigue

With regard to postpartum depression, it is common for new mothers to experience tearfulness, fatigue, exhaustion, irritability and feelings of being overwhelmed. Often referred to as the “baby blues,” these feelings are experienced by 50-80% of all new moms. For most women the “baby blues” usually go away in one to two weeks. However, as noted above, 10% to 15% of new mothers actually develop postpartum depression or anxiety disorder. These feelings can appear anytime during the first few months to one year after the birth. In these cases, the “blues” seem to worsen over a six to eight week period. There is a greater intensity of symptoms and more bad days than good.

Postpartum Psychosis is a rare disorder that affects approximately two new mothers per 1,000 births. In these cases a woman has difficulty thinking clearly and perhaps has hallucinations or delusions. In a woman who has had one episode of postpartum psychosis, the risk of a future episode is greater than 50%.<sup>37</sup>

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### **Youth and Depression**

As noted earlier, it is estimated that one in eight adolescents suffers from depression. The following section looks more closely at teens and suicide.

## Section III: Suicide

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Depression is considered to be a predisposing agent in suicide and is associated with about half of all suicides. **Over a ten-year period there are more than 2000 suicides among residents of the five counties in the metropolitan Kansas City area.** Suicide deaths by county were as follows for the periods indicated:

Missouri (1992-2002) <sup>38</sup>	
Clay County	266
Jackson County	1,028
Platte County	98
Kansas (1989-1998) <sup>39</sup>	
Johnson County	382
Wyandotte County	232

With respect to how we compare with others, a report released by the UAW-Ford Community Health Initiative in April, 2002, stated the following: In general, greater Kansas City area<sup>40</sup> residents experience a slightly higher suicide rate, losing more years of life compared to most state, national and comparison community experiences.<sup>41</sup>

- ◆ With the exception of Missouri, the rate of suicide in the greater KC area in 1995 (12.4 deaths per 100,000 persons) was 2% to 22% higher than benchmarks.<sup>42</sup>
- ◆ Greater KC area residents lost more years of life due to suicide (353 years per 100,000 persons) relative to those lost in Kansas, Missouri, the U.S. and comparison communities.
- ◆ In 1995, although suicide death rates vary little by county, Wyandotte County residents lost the most years of life due to suicide (430 years per 100,000 persons).<sup>43</sup>

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## Suicide Prevalence

- ◆ Suicide is the eighth leading cause of death for all Americans and is the third leading cause of death for people ages 15 to 24.
- ◆ While the *numbers* of suicides are greater among younger age cohorts, suicide *rates* are the highest among people age 65 and older.
- ◆ The age-adjusted suicide rate in the total population has slightly declined and by 1997 already had met the *Healthy People 2010* target level of 6.0 suicides per 100,000.
- ◆ White men ages 65 and older who began the 1990's at the highest risk for suicide (44.4 per 100,000), had declined below the year 2000 target by 1994 (38.9) and had declined further by 1997 (35.5).<sup>44</sup>
- ◆ From 1992-2001, the suicide rate among youths 10 to 19 years old declined from 6.2 to 4.6 per 100,000 population, a decrease of 25%.<sup>45</sup>
- ◆ The people most at risk for committing suicide are those who have several of the following characteristics:
  - have attempted suicide in the past
  - have a family history of suicide
  - have a firearm in the home
  - consume alcohol and/or abuse other substances
  - are depressed
  - have experienced violence (physical, domestic, or child abuse)
  - are experiencing unusual stress due to adverse life events, such as separation or divorce or job loss
  - have spent time in jail or prison
  - have a medical condition
  - move frequently from one location to another
  - experienced poor parent/child communication feel socially isolated<sup>46</sup>

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## Older Adults and Suicide

Comprising only 13% of the U.S. population, individuals ages 65 and older account for 20% of all suicide deaths. Further, elderly men account for about 80% of suicides among persons ages 65 years and older. White males are particularly vulnerable. The suicide rate for white men ages 85 and older is about six times the national U.S. rate.<sup>47</sup> Even at this rate, since national statistics are unlikely to include more veiled forms of suicide, such as a nursing home resident who decides to stop eating, estimates are probably conservative.<sup>48</sup>

Suicide in older adults is most associated with late-onset depression<sup>49</sup>: among persons 75 years of age and older, 60 to 75% of suicides have diagnosable depression. Swedish researchers found among adults aged 85 years and older a 1-month prevalence of any suicidal feelings in 9.6% of men and 18.7% of women. Suicidal feelings were strongly associated with depression. Almost 50% of those meeting criteria for depression reported such thoughts.

Remarkably, studies of older persons who have committed suicide have revealed that older adults had seen their physician within a short interval of completing suicide, yet few were receiving mental health treatment.

**According to one study, among older adults who committed suicide, 20% had visited their primary care physician on the same day, 40% had visited their primary care physician within one week, and 70% had visited their primary care physician within one month of the suicide.<sup>50</sup>**

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## Teen Suicide

Suicides among adolescents are especially tragic. Suicide is now the second most frequent cause of death, after accidents, among high school students.<sup>51</sup> Further, a number of “accidents” may in fact be suicides, given the stigma surrounding suicide and a desire to “protect the family” that results in misreporting by some county coroners and medical examiners.<sup>52</sup>

The National Youth Risk Behavior Surveillance System, established by the CDC to monitor the prevalence of youth behaviors that most influence health, encourages states to administer school-based surveys regarding health-risk behaviors.

**In 2003, among Missouri students grades 9-12, more than one in five girls and more than one in ten boys indicated that they had seriously considered attempting suicide during the previous 12 months. Of these, 7.3% indicated that they had actually attempted suicide one or more times during that time period (9.8% of girls – almost one in ten – and 4.8% of boys).<sup>53</sup>**

**In 2003, among Kansas students grades 9-12, 17.8% indicated that they had ever seriously considered attempting suicide. Of these, 6.1% indicated that they actually had attempted suicide one or more times in the previous 12 months.<sup>54</sup>**

**Latino youth are at significantly high risk for poor mental health outcomes.**

A full understanding of which youth are at greater risk is important for prevention efforts. For example, in addition to gender differences, it is known that Latino youth are at significantly high risk for poor mental health outcomes (though this is not reflected in the earlier depression prevalence estimates). Evidence suggests that they are more likely to drop out of school, to report depression and anxiety, and to consider suicide than non-Hispanic white youth.<sup>55</sup>

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### **Gays, Lesbians, Bisexuals and Suicide**

A 1989 report from the US Department of Health (now Health and Human Services) on youth suicide found that gay and lesbian youth are up to five times more likely to attempt suicide than are straight youth. The report said the increased risk among these youths is due to isolation, rejection, confusion, and shame due to the stigmatization of homosexuality, which results in depression, suicide, and low self-esteem.<sup>56</sup>

The local survey<sup>57</sup> of gays, lesbians, and bisexuals asked how frequently respondents had ideations about suicide.

◆7% of gays reported “almost always” (1%), “very often” (2%) or “often” (4%).

◆9% of lesbians reported “almost always” (1%), “very often” (3%) or “often” (5%).

◆13% of bisexuals reported “almost always” (3%), “very often” (1%) or “often” (9%).

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### **Native Americans and Suicide**

The suicide rate among American Indians/Alaska Natives is 50% higher than the national rate; rates of co-occurring mental illness and substance abuse (especially alcohol) are also higher among Native youth and adults. Because only limited data have been collected, the full nature, extent and sources of these disparities remain a matter of conjecture.<sup>58</sup>

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### **Suicide Among Pregnant and Postpartum Women**

Data are not currently available on the incidence of suicide among women with perinatal mood disorders.<sup>59</sup> Experts agree the lack of such information hinders a full understanding of this issue and the development of strategies to address it.

## Section IV: Treatment For Depression

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Treatment can alleviate depression. Available medications and psychological treatments, alone or in combination, can help 80% of those with depression. Yet, nationally in 1997 only 23% of adults diagnosed with depression received treatment.

This was down from nearly 30% receiving treatment in 1996. The Healthy People 2010 target is that 50% of adults diagnosed with depression receive treatment. (In comparison, 60 to 80% of persons with heart disease seek and receive care.) Treatment levels are even more dismal for certain populations as shown in the following table.

<i>Treatment Levels Among Various Populations: Percent of Adults ages 18 and older with recognized depression receiving treatment, 1997.<sup>60</sup></i>	
Total	23%
<b>By race and ethnicity</b>	
African American	16%
White	24%
Hispanic	20%
<b>By gender</b>	
Female	24%
Male	21%
<b>By educational level</b>	
Less than high school	22%
High school graduate	19%
At least some college	28%

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## Treatment Issues

In the metropolitan Kansas City area, as in other areas of the country, there is a substantial network of public and private sector providers available to treat persons with mental health problems. There are many reasons why people in need of care are not getting it. The large unmet need for treatment of mental disorders reflects *patient* barriers (e.g., preference for primary care, tendency to emphasize somatic problems), *provider* barriers (e.g., lack of awareness of the manifestations of mental disorders, complexity of treatment, and reluctance to inform patients of a diagnosis, and system barriers (e.g., time pressures, reimbursement policies). Additionally:

- ◆ Some people are reluctant to seek treatment, believing the problem will go away on its own.
- ◆ Some people do not realize that their symptoms (e.g., lack of energy, hopelessness) indicate an illness that is treatable.
- ◆ Society still attaches stigma to mental health problems, making people reluctant to admit they have such problems and seek care.
- ◆ In many cases insurance coverage for mental health treatment and prescriptions is not as generous as it is for other medical problems, making co-payments unaffordable for some.

Some physicians are not adequately prepared to diagnose and treat depression or know when to refer.

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## Racial and Ethnic Minorities and Treatment

There are additional issues facing racial and ethnic minority Americans who need treatment for depression.

- ◆ According to the US Surgeon General, striking disparities continue in access to, and quality and availability of, mental health services for racial and ethnic minority populations.<sup>61</sup> A critical consequence is that racial and ethnic minority communities bear a disproportionately high burden of disability from untreated or inadequately treated mental health problems and mental illnesses.

**Ethnic and racial groups experience depression and express its symptoms differently.**

- ◆ Culturally competent clinicians are not always available.
- ◆ Linguistically similar providers are not always available. For example, among Hispanic Americans, as many as 40% report limited English-language proficiency. Because few mental health care providers identify themselves as Spanish-speaking, most Hispanic Americans have limited access to ethnically or linguistically similar providers.
- ◆ Disproportionate numbers of minority members are found among populations at increased risk for mental disorders and where treatment availability is most lacking – these include the homeless, persons who are incarcerated, those in the child welfare system, and victims of trauma.
- ◆ Ethnic and racial groups experience depression and express its symptoms differently. For example, words such as “depressed” and “anxious” are absent from some American Indian languages.<sup>63</sup> Instead they describe what others call “depressive symptoms” as “being out of balance” mentally, physically and spiritually.<sup>63</sup> Among Latinos, the expression of distress through somatic symptoms has been noted by researchers.<sup>64</sup> Also, culture-bound syndromes such as *susto* (fright) and *nervios* (nerves) are frequently experienced by Latinos.<sup>65</sup> Such syndromes are in fact recognized in the appendix of DSM-IV (the tool used by providers to diagnose mental problems). Among African American women there is often an expectation that being blue or depressed is an expected and accepted life experience.<sup>66</sup> Asian Americans/Pacific Islanders who seek care for a mental illness often present with more severe illnesses than do other racial or ethnic groups. This, in part, suggests that stigma and shame are critical deterrents to service utilization. It is also possible that mental illnesses may be undiagnosed or treated early in their course because they are expressed in symptoms of a physical nature.<sup>67</sup>

As was noted with respect to gaining a full understanding of prevalence, few studies on the response of certain ethnic and racial minority groups

are available. For example, with respect to Latinos, only three small studies of depression have been published, one investigating the care for depression given to unmarried Puerto Rican mothers with depressive symptoms, another to Mexican American women, and one to Puerto Rican adolescents.<sup>68</sup>

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### **Older Americans and Treatment<sup>69</sup>**

The elderly who suffer from depression present other challenges.

◆ There are many barriers to the *diagnosis* of depression in late life. Some of these barriers reflect the nature of the disorder: depression occurs in a complex medical and psychosocial context. In the elderly, the signs and symptoms of major depression are frequently attributed to “normal aging,” atherosclerosis, Alzheimer’s disease, or any of a host of other age-associated afflictions. Psychosocial antecedents such as loss, combined with decrements in physical health and sensory impairment, can also divert attention from clinical depression. Another reason for the underdiagnosis is that older patients are less likely to report symptoms of dysphoria and worthlessness, which are often considered hallmarks of the diagnosis of depression. Further, the clinical presentation of older adults with mental disorders may be different from that of other adults, making detection of treatable illness more difficult.

◆ There is consistent evidence that older patients, even the very old, respond to antidepressant medication (60 to 80% vs. a 30 to 40% response rate to placebo) – though the response to medications among older adults generally takes longer than that for other adults. Combining pharmacotherapy with psychosocial interventions also appears to be effective in older depressed patients. Yet, because patients 75 years old and older typically have higher prevalence of medical comorbidity, both they and their physicians are often reluctant to add another medication to an already complex regimen in a frail individual. In short, pharmacological treatment of depression in older people is similar to that in other adults, but the selection of medications is more complex because of side effects and interactions with other medications for concomitant somatic disorders.

- ◆ Compliance with treatment regimens also is a special concern in older adults, especially in those with moderate or severe cognitive deficits. Physical problems, such as impaired vision, make it likely that instructions may be misread or that one medicine may be mistaken for another. The most common type of deliberate noncompliance among older adults may be the underuse of the prescribed drug, mainly because of side effects and cost considerations. Factors that contribute to medication noncompliance in older patients include inadequate information given to them regarding the necessity for drug treatment, unclear prescribing directions, suboptimal doctor-patient relationship, the large number of times per day drugs must be taken, and the large number of drugs that are taken at the same time.
  
- ◆ In late life, the course of depression tends to be more chronic than that in younger adults. This means that recurrences extend for longer duration, while intervals of remission are shorter. Further, cycles of recurrence and remission persist over a longer period of time.
  
- ◆ There is fragmentation and insufficient availability of treatment in community-based settings. Services for older adults are often divided between systems of health, mental health, and social services. Although every community has an Administration on Aging to assist with services for older adults generally, there is no administrative body responsible for integrating the daunting array of services needed specifically for individuals with severe mental illnesses.
  
- ◆ Because of ethnic diversity in the U.S., systems of care must also deal with the special needs of older Americans who have limited English proficiency and different cultural backgrounds.

Other issues related to depression among older adults are:

- ◆ Late-life depression is particularly costly because of the excess disability that it causes and its deleterious interaction with physical

health. Older primary care patients with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer at the hospital.

- ◆ Late-life mental disorders often pose difficulties for the family members who assist in caretaking tasks for their loved ones. One consequence is that depression among caregivers is common.

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### **Sexual Minorities and Treatment**

For sexual minorities, the stigma associated with being a sexual minority may become a barrier in seeking adequate health care.<sup>70</sup> Further, the lack of inclusion of sexual orientation issues in research tools, the lack of understanding and sensitivity by medical care systems, and the lack of recognition of the specific needs of sexual minorities by funding sources can contribute to lesbian, gay, bisexual and transgendered<sup>71</sup> individuals either not seeking care or receiving care that is not sensitive to the issues of being a sexual minority. A researcher on gay health notes, "It's the stress of being stigmatized. It's not so much that sexual orientation itself carries health [and mental health] problems, but society's reaction to it."<sup>72</sup>

Children and adolescents may be most vulnerable. Within the developmental life cycle, most children and youth feel awkward and embarrassed by sexual conflicts. Sexually diverse youth may have an even more difficult time in that their sexuality is not adequately acknowledged.

Because many mental health professionals are not sensitive to the issues gay clients bring to them, special efforts are often needed to identify those mental health professionals who are sensitive to these. In Kansas City, for example, the Lesbian and Gay Community Center has compiled a list of such practitioners.

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### **Pregnant and Postpartum Women and Treatment**

The identification of depression during pregnancy is especially important since it may affect birth weight and gestational age. However, as in the population as a whole, only a fraction of those needing treatment will

receive it. It is estimated that only 20% of pregnant women who need treatment will receive it.

With respect to early identification, many physicians minimize the symptoms of depression and the need for treatment. In fact, studies have shown that screening tools such as the Edinburgh Postnatal Depression and Postpartum Depression Screening Scales are presently underutilized in ob/gyn, family practice and pediatric clinics.<sup>73</sup> Among women themselves, many embrace the “motherhood myth” best described as society’s insistence that women be the perfect mothers. As a result, they are often reluctant to share their real feelings of being overwhelmed and stressed by the requirements of motherhood, and hence in need of treatment. Further, many prenatal classes lack adequate information about perinatal depression and anxiety disorders; so women and their families are not always aware of the symptoms of depression and knowledgeable about treatment resources in their communities.

In addition, as with others in our society, many women have inadequate or no health insurance coverage for treatment. For women with depressive symptoms, a complete physical examination including thyroid tests for hormonal imbalances should be completed, along with an assessment of the need for medications. The most common types of medications used for perinatal depression are antidepressants, antianxiety medications, mood stabilizers and antipsychotics. However, it should be noted that the pharmacotherapy of depression among pregnant women is complicated by the effects of drugs on the fetus and, among postpartum women, on the infant if the mother breast-feeds. Psychotherapy is often combined with medication therapies or used alone.

**It is estimated that only 20% of pregnant women who need treatment will receive it.**

Support groups are important for women with postpartum depression and anxiety because they help reduce the women’s sense of guilt and isolation. Hospitalization is utilized for women who do not respond well to medications and therapy and who express thoughts of suicide or harming their baby.

## Section IV: Efforts In Kansas City to Address Depression

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Leaders from a number of sectors in the community (in addition to mental health providers who are engaged daily in the promotion of mental health among our residents) have come together in various forums to try to understand the nature and magnitude of depression among different subsets of our population, and to identify and address problems surrounding the prevention, diagnosis and treatment of depression. These leaders also encouraged the Metropolitan Health Council to undertake a review of the issue of depression in our community and to gather the information in this report.

In addition to the ongoing and commendable work that is done in the community mental health centers in our community and by mental health providers in the private sector, the following notable initiatives that have taken place or are now are underway to study and/or address issues concerning depression in Kansas City.

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### ◆KCQIC's Depression Guidelines

The Kansas City Quality Improvement Coalition (KCQIC), a collaborative of local medical societies and health care organizations, has developed and distributed to area primary care physicians “best practice” guidelines on management of depression. (KCQIC has developed and distributed similar guidelines on several other chronic diseases as well.) KCQIC was established after the UAW-Ford Kansas City Community Health Care Initiative shared local data and started discussion on the best ways to support benchmark clinical practice. The group’s aim is to promote “best practices” and bring consistency to the clinical practice guidelines endorsed by regional health care organizations. Kansas City is the only place in the nation where all major health plans and medical organizations have participated in developing common sets of clinical guidelines

which are then distributed to their participating/member primary care physicians. The significance of this activity with respect to depression is that research shows that many people turn to their primary care physicians for help with depression, while some primary care physicians are not adequately prepared to respond appropriately.

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**◆Mid-America Coalition on Health Care's  
Community Initiative on Depression**

In 1998, the Mid-America Coalition on Health Care (MACHC) embarked on a project with eight Kansas City area employers to identify the leading health risks in their employed population and their dependents. After administering the CDC's Behavioral Risk Factor Surveillance Survey to employees at these worksites and reviewing the results, a consensus was reached by the participating employers to focus their efforts on the human and financial costs of depression – one of the most prevalent and undiagnosed diseases in the workplace and community. MACHC's resulting Community Initiative on Depression has as its broad objectives to de-stigmatize depression, identify the direct and indirect costs of depression, and to create a community infrastructure to support its appropriate detection, diagnosis, treatment and adherence to treatment. The project has grown and now involves fourteen employers representing 140,000 covered lives. The Initiative has brought together 14 major employers, 11 health plans, and managers of some of the area's larger medical practices to collaborate on increasing depression awareness and addressing treatment issues. The Coalition has received national attention for its groundbreaking nature. Dr. David Satcher, US Surgeon General, said of the initiative that the MACHC's activities will "undoubtedly serve as a model in the future for other communities nationwide." MACHC is actively involved in other efforts to heighten awareness about depression in the Kansas City area and address prevention and treatment issues. Among these:

–On March 29, 2005, MACHC will staff a town hall meeting on depression for members of the Greater Kansas City Area Chamber of Commerce. The following day MACHC will host an invitational symposium for leaders from other communities from around the U.S., to share tools and lessons learned from the “depression and the workplace” studies and activities that have taken place or are currently underway here. MACHC will also participate in the first World Congress on Mental Health and Wellness in Baltimore, Maryland, on May 2-3, 2005.

–MACHC continues to be involved in its project to improve medical record coding for depression and has initiated a demonstration project to incorporate depression screening in several specialty areas where depression is known to be a co-morbidity.

–MACHC is providing staffing assistance for several activities associated with the new “Kansas City Suicide Awareness and Prevention Project.” The activities have included a Suicide Prevention Town Hall Meeting, an Out of the Darkness KC Walk, and a Survivor and Mental Health provider Web Cast. There are a number of coordinating agencies involved in these activities as well.

–Information on depression and its treatment will be available for employees, workplace managers, mental health providers and physicians at [www.MSCHC.org](http://www.MSCHC.org) in November, 2004.

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#### **♦Kansas City Lesbian, Gay, Bisexual, and Transgendered Community Health Assessment**

In the spring and summer of 2003, the Kansas City Health Department joined with the Lesbian and Gay Community Center of Greater Kansas City in developing and administering a survey to nearly 1,500 gay, lesbian, and bisexual men and women in our community in order to learn more about health

and social issues affecting them.<sup>74</sup> As reported in the Kansas City Star, this survey “is one of the few attempts [nationwide] to gain a thorough understanding of a gay community’s health, and it’s already being applauded by national experts.”<sup>75</sup> A substantial finding relates to the degree to which these groups experience feelings of depression, and this information is noted earlier in this present report.

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♦ ***Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri***

Released in June, 2003, this, too, is a landmark report. It was prepared by the Mattie Rhodes Center, an organization that offers bilingual (Spanish and English) social services, mental health, counseling, and art experiences, primarily to Latinos in our community. The report aims to improve the knowledge and understanding of issues related to cultural competency and mental health among area civic leaders, public officials, social service providers, and others. Sections of the report examine depression in Latino communities and barriers to care.

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♦ **Mental Health Association of the Heartland (MHAH)**

This bistate advocacy, education, and support organization with offices in Kansas City, Kansas, aims to promote the mental health of the community. Several of its efforts of particular note in the current context include a) a publication called *In the Company of Others: 2002 Kansas City Self-Help & Support Group Directory*; b) educational programs on postpartum depression; c) educational programs for the clergy on depression; and d) sponsorship of a teen suicide prevention program called A.N.S.W.E.R. (See program description below.) MHAH is also designated as an outreach partner of the National Institute of Mental Health and, as such, has available copies of NIMH’s many brochures and booklets covering various facets of mental health/illness including depression.

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### ◆Teen Suicide Initiatives

In the Kansas City area, interest has been high in the mental health, school and law enforcement communities in addressing teen suicide. Efforts on the Missouri side include the Safe Passages program looking at teen violence, of which teen suicide is a piece. Several of the Caring Communities<sup>76</sup> sites are working on the issue as it relates to their individual site needs; and some community mental health centers have programs addressing teen violence and suicide.

On the Kansas side, a broad-based coalition organized in 1998 by law enforcement officers in Overland Park has been working on the issue of teen suicide. Called A.N.S.W.E.R. (Adolescents Never Suicide When Everyone Responds), the aim is to increase public awareness of teen suicide and, with funding from a SAMHSA grant and local sources, the Mental Health Association of the Heartland provides classroom presentations and workshops for students and teachers in Johnson and Wyandotte Counties and staffs a teen suicide helpline. The grant also funded the development of a website and a video on teen suicide issues, including depression.

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### ◆Primary Care/Mental Health Integration Modeling

Studies have shown that 30 to 50% of patients in primary care settings have anxiety or depressive disorders.<sup>4</sup> Although only a minority of persons seek professional help to relieve a mood disorder, depressed people are more likely than others to visit a physician for some other reason.<sup>5</sup> A local survey of employees of major employers in the greater Kansas City area found that 76% of respondents indicated they would go to their family doctor for help or for more information if they had depression, while fewer said they would seek help or information from a psychologist/counselor (70%) or psychiatrist (43%). (Multiple responses were allowed.)<sup>6</sup> Yet, studies also show that primary

care clinicians underdiagnose depressive disorder.<sup>7</sup> In response, new models are being developed that strive to integrate into the primary care setting the delivery of specialty mental health services. These new models of service delivery in primary care include mental health teams, consultation-liaison models (mental health specialist is called in as a consultant at request of PCP) and integration of mental health professionals into primary care.<sup>8</sup> Locally, Tri-County Mental Services, Swope Health Services, and Truman Medical Center have developed unique integration service delivery models.

## Section VI: Activities Recommended By The Metropolitan Health Council

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### Depression and Faith Communities Initiative

Employees participating in Mid-America Health Care Coalition's survey<sup>1</sup> were asked "If you or a loved one had depression, which of the following would you use or suggest?" and were to indicate Herbal Supplements or Vitamins, Exercise, Prescription Drug Therapy, and/or Counseling. Other responses were also solicited. The most common "other" response was Prayer, and among the top ten other responses, five were related to seeking assistance through their religion or spiritual community.

In reviewing the survey findings and other sources of information that suggest that the faith community is an important resource for persons experiencing depression, the Metropolitan Health Council sought to identify initiatives in the Kansas City area aimed at assuring that clergy and laypersons are prepared to respond adequately to congregants who are depressed. The Mental Health Association of the Heartland has held educational seminars for clergy and lay persons. Also, area churches have mounted individual efforts for clergy and laypersons. One of these, the Stephen Ministry at Leawood Methodist Church, has chosen depression for an educational series that is currently underway. Still, it seemed there was no community-wide effort to address depression in the way the community had worked on end-of-life issues through the *Compassion Sabbath* campaign mounted by local clergy persons and the Midwest Bioethics Center (now the Center for Practical Bioethics) a few years ago. That project educated faith communities about death/dying and gave them tools to use to promote advance care planning among congregants for end of life healthcare. Several area ministers suggested that the *Compassion Sabbath* concept and process – and even many of the participants – might be useful in planning a similar effort focusing on depression. As a result, the Center for Practical Bioethics and the Mental Health Association of the Heartland have developed a proposal and are actively seeking funding to mount a *Compassion Sabbath of Hope for Depression* campaign. Aimed at bolstering the ability of clergy and lay

leaders within Kansas City's faith communities to identify and address depression among congregants, the approach would build on lessons learned during the previous *Compassion Sabbath* campaign. As outlined in the proposal, the campaign would draw together approximately twenty faith community leaders and mental health professionals as a Task Force to plan an event showcasing educational and liturgical resources compiled for use by at least 100 congregations on the first annual *Compassion Sabbath of Hope* weekend, to take place in 2005. Expanded educational offerings and an ongoing online learning option would be available to congregations thereafter. The proposed project period is two years.

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**Development/distribution of lay brochure based on KCQIC Depression Guidelines**

Metropolitan Health Council members have asked KCQIC (see above) to translate the Depression Guidelines that group developed for use by area physicians, into lay language to help patients dealing with depression know what to ask for and expect from their physicians. The UAW/Ford Community Health Initiative staff and KCQIC members have already completed translating the group's Diabetes Guidelines into a similar brochure. Local health plans have indicated a willingness to distribute such a brochure on depression to their participating providers for patient use.

## Section VII: Conclusion

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Clearly, this report can only scratch the surface of the topic of depression and how Kansas City is responding and needs to respond. We hope that it piques readers' interest in finding out more – or in becoming involved in some of the efforts that are underway.

The main points we hope readers take away from the report are:

1. Depression is a profound problem in our community given its scope, how it affects people's quality of life, and its economic impact.
2. Depression is diagnosable and treatable.
3. Efforts in our community aimed at addressing depression and the stigma surrounding it are to be commended and need to continue.

Additional training is needed to support those in faith communities to whom depressed persons turn for help.

# Endnotes

- <sup>1</sup>The Metropolitan Health Council is a non-partisan group, brought together by Prime Health Foundation, dedicated to facilitating community responses to health problems in the Kansas City metropolitan area.
- <sup>2</sup>Leonardo Tondo, MD, and Ross J. Baldessarini, MD. *Suicide: Historical, Descriptive, and Epidemiological Considerations*. March 15, 2001. www.medscape.com
- <sup>3</sup>National Mental Health Association. www.nmha.gov. See "depression and children."
- <sup>4</sup>Daniel J. Contri and Wayne N. Burton, *The Economic Impact of Depression in a Workplace*, Journal of Occupational Medicine. Vol. 36, No. 9, Sept 1994, p. 983.
- <sup>5</sup>Ibid.
- <sup>6</sup>Healthy People 2010, p. 18-5.
- <sup>7</sup>Clay, Jackson & Platte in MO and Johnson and Wyandotte in KS.
- <sup>8</sup>National Mental Health Association. www.nmha.org.
- <sup>9</sup>Essex, Klein, Meich and Smider. *Timing of Initial Exposure to Maternal Major Depression and Children's Mental Health Symptoms in Kindergarten*. The British Journal of Psychiatry. (2001) 179: 151-156.
- <sup>10</sup>American Academy of Child & Adolescent Psychiatry website: www.aacap.org/publications/factsfam/depressed.htm
- <sup>11</sup>Personal communication from Susan Crain Lewis, President and CEO, Mental Health Association of the Heartland.
- <sup>12</sup>Healthy People 2010, p. 18-5,6.
- <sup>13</sup>The source for much of the information regarding older adults and depression in this report is *Mental Health: A Report of the Surgeon General*. 1999. Ch. 5. Hereinafter referenced as *Mental Health*. Reference pages are indicated. Other citations are from NIMH publications and are indented.
- <sup>14</sup>According to the 2000 U.S. census, there are 173,949 persons 65+ in the five county KC metro area. 8% of this is 13,916; 20% is 34,790.
- <sup>15</sup>*Mental Health*. Op. cit. p. 347.
- <sup>16</sup>*Mental Health*. Op. cit. p. 336.
- <sup>17</sup>*Mental Health*. Op. cit. p. 348.
- <sup>18</sup>Healthy People 2010. Vol I pps. 36-37.
- <sup>19</sup>Emily Saez-Santiago and Guillermo Bernal, *Depression in Ethnic Minorities*, Chapter 19, p. 5.
- <sup>20</sup>Epidemiologic Catchment Area Study. Discussed in Ibid., p. 5.
- <sup>21</sup>National Comorbidity Survey. Discussed in Ibid., p. 5.
- <sup>22</sup>See for example Vega, W. *Hispanic mental health research and disparities in service*. Referenced in Ibid. p. 6.
- <sup>23</sup>Ibid. p. 23.
- <sup>24</sup>Ibid., pps. 21-22.
- <sup>25</sup>Ibid. p. 4.
- <sup>26</sup>Ethnocentric bias refers to the tendency to view one's own ethnic group or culture as the gold standard against which other ethnic groups are evaluated.
- <sup>27</sup>The Pulse: The Kansas City/LGBT Community Health Assessment, April 2004.
- <sup>28</sup>This included responses of "almost always" at 5%; "very often" at 11%; and "often" at 14%.
- <sup>29</sup>This included responses of "almost always" at 6%; "very often" at 12%; and "often" at 13%.
- <sup>30</sup>This included responses of "almost always" at 10%; "very often" at 19%; and "often" at 13%. In addition to having the highest response rate regarding depression, bisexuals report other behaviors such as "drinking to get drunk" (page 60) and "recreational use of marijuana" (page 63).
- <sup>31</sup>The question was "In the last (3) years, how often have you found symptoms of depression (i.e. hopelessness, helplessness, anxiousness, worthlessness, isolation, etc.) to negatively affect your normal activities?"
- <sup>32</sup>The Pulse. Op.cit., ps. 36.
- <sup>33</sup>Gay and Lesbian Medical Association. *Healthy People 2010: Companion document for Lesbian, Gay, Bisexual, and Transgender Health*, April 2001, p. 206.
- <sup>34</sup>Pearlstein, Teri et al. *Dysphoric Disorders in Women: A Case of Perinatal Depression*. *Perinatal Depression: An Overview*. Posted 7/1/98. See www.medscape.com/viewarticle.
- <sup>35</sup>O'Hara, NW. *Postpartum Depression: Causes and Consequences*. Referenced in Ibid.
- <sup>36</sup>Bennett, SS & Indman, P. *Beyond the Blues: A guide to Understanding and Treating Prenatal and Postpartum Depression*. 2003.
- <sup>37</sup>Pearlstein, Op. cit.
- <sup>38</sup>Missouri Department of Health and Social Services.
- <sup>39</sup>Kansas Department of Health and Environment.
- <sup>40</sup>Includes Platte, Clay and Jackson Counties in Missouri; Wyandotte and Johnson Counties in Kansas.
- <sup>41</sup>The Lewin Group, Inc. *Community Assessment Factbook: Greater Kansas City Area*, p.249.
- <sup>42</sup>Benchmarks include state and national comparisons and several other cities of similar size. *Healthy People 2010* has a goal of 6.0 suicides per 100,000.
- <sup>43</sup>Lewin, Op. cit. p. 251.
- <sup>44</sup>Healthy People, Op. cit. p. 18-10.
- <sup>45</sup>CDC. *Methods of Suicide by Persons Aged 10-19 Years*, United States, 1992-2001. MMWR 2004;53 (22), 471-474.
- <sup>46</sup>CDC website.
- <sup>47</sup>NIMH. *Older Adults Depression and Suicide Facts*. Pamphlet available from Mental Health Association of the Heartland.
- <sup>48</sup>The source for this and the following information on older adults and suicide, unless otherwise noted, is *Mental Health: A Report of the Surgeon General*. Dec. 1999. Chapter 5. pps. 350-351. See at www.surgeongeneral.gov/library/mentalhealth/home
- <sup>49</sup>Depression diagnosed with first onset later than age 60 has been termed late-onset depression. Patients with late-onset depression display greater apathy. Cognitive deficits may be more prominent, with more impaired executive and memory function. The risk of recurrence of depression is relatively high among patients with onset of depression after the age of 60. (p. 347) Risk factors for late-onset depression include persistent insomnia (occurring in 5 to 10% of older adults); grief (10 to 20% of widows and widowers develop clinically significant depression during the first year of bereavement); and possibly structural, neuroanatomic factors. *Mental Health*, Op. cit. p. 351.
- <sup>50</sup>NIMH. *Older Adults Depression and Suicide Facts*. Pamphlet available from Mental Health Association of the Heartland.
- <sup>51</sup>Goldstein, op. cit. P. 11.
- <sup>52</sup>Both Susan Lewis, CEO of the Mental Health Association of the Heartland and Sgt. Barbara Walk, co-chair of ANSWER (see page 16) note that accurate information on teen suicide is not available. As with domestic violence, coding by law enforcement officers to record suicide is not consistent. In addition, pathologists often do not code suicide correctly.
- <sup>53</sup>Missouri Department of Education. County-level data not available.
- <sup>54</sup>Personal communication from Dr. Darrel Lang, consultant who is responsible for analyzing YRBSS data for Kansas Department of Education. Contact information: Phone: 785-296-6716. Email dlang@ksde.org
- <sup>55</sup>*Mental Health: Culture, Race and Ethnicity*. US Office of the Surgeon General, August, 2001. This report, a supplement to the 1999 Surgeon General's report on mental health, highlights the role culture and society play in mental health, mental illness, and the types of mental health services people seek. Chapter 6, *Mental Health Care for Hispanic Americans*. Conclusion. Pamphlet available from Mental Health Association of the Heartland. Hereinafter this publication is referenced as *Mental Health Supplement*.
- <sup>56</sup>Fleischer and Fillman. (1995). *Lesbian and Gay Youth: Treatment Issues*. *The Counselor*, Vol. 13, No. 1, 2, 27-28.
- <sup>57</sup>*The Pulse*. Op. cit. p. 35.
- <sup>58</sup>Santiago, Op. cit.
- <sup>59</sup>Personal communication to Kathleen O'Kane from Eric D. Caine, MD, and Linda Chaudron, MD, MS, University of Rochester Medical Center's Center for Suicide Studies.
- <sup>60</sup>Healthy People 2010. P. 18-9b.
- <sup>61</sup>*Mental Health Supplement*. Op. cit. p. 1. See also Mattie Rhodes Center, *Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri*. June 2003, p. 52.
- <sup>62</sup>*Mental Health Supplement*. Op. cit. Chapter 4. *Mental Health for American Indians and Alaska Natives*, p. 2.
- <sup>63</sup>Personal communication from Gayl Edmunds, Director, Morning Star Program, Heart of America Indian Center, KC, MO.
- <sup>64</sup>US Surgeon General. *Mental Health*. Op. cit. Chapter 6 on Mental Health and Hispanic Americans, p. 10. Also Mattie Rhodes. Op. cit. p. 49.
- <sup>65</sup>Ibid. p. 11.
- <sup>66</sup>Personal communication from Rev. Denise Graves, Wyandotte Interfaith Coordinating Council.
- <sup>67</sup>Santiago, Op. cit.
- <sup>68</sup>*Mental Health Supplement*. Op. cit. Chapter 6. p. 144.
- <sup>69</sup>Information in this section is taken primarily from *Mental Health: A Report of the Surgeon General*. Op. cit. Chapter 5. pps. 348-371.
- <sup>70</sup>This and the following sentences are taken from page 9 of The Pulse project report. Though the quotes refer in the report to barriers to receiving adequate health care, the statements likely cover similar issues for those seeking mental health care.
- <sup>71</sup>In The Pulse study, transgendered individuals were self identified as male-to-female or female-to-male, or whose behavior make them identify as transgendered.
- <sup>72</sup>Anthony Silvestre, a University of Pittsburgh researcher. Quoted in Kansas City Star article on The Pulse report. April 3, 2004. P. B2.
- <sup>73</sup>Gruen, D.S., (1990). *Postpartum Depression: A Debilitating Yet Often Unassessed Problem*. *Health and Social Work* 15 (4), 1-12.

