African Americans, Latinos, and Asian Americans are less likely to use outpatient services than are white people. However, African Americans are overrepresented in inpatient psychiatric units (SAMHSA, 2015b). A combination of factors may account for this, including overt discrimination (perceiving clients of color as more dangerous or more impaired), limited access to outpatient treatment due to lack of availability or affordability, and differences in help-seeking behaviors such as delaying seeking help until conditions have worsened.

Members of a number of nondominant groups are at increased risk for serious mental illness. Research has found disparities based on race, ethnicity, gender, socioeconomic status, geographic location (urban vs. rural), sexual orientation, and primary language (Evans, Berkman Brown, Gaynes, & Weber, 2016). The reasons for the disparities in mental health status are still being debated and likely differ depending on the group involved. However, a number of theories have been offered. The stress of oppression and poverty may promote the development of psychiatric conditions. This may be particularly true for anxiety or clinical depression. It is also likely that lack of access to insurance and affordable care might mean that members of all of these groups do not get care until their conditions have become increasingly serious.

Ethnopsychopharmacology is a growing area of study that looks at the way ethnic and cultural influences affect a client's response to medication. There is increasing evidence that there are significant differences in response to drugs used to treat mental illness among members of different racial and ethnic groups. For example, there is some evidence that Asian Americans and Latinos with schizophrenia may require lower doses of antipsychotic medications than white Americans. These differences are believed to be due to a combination of factors, including genetics, diet, and health behaviors (Yeung & Kam, 2006).

Strengths Perspective LO 7

Social workers bring a strengths perspective to the multidisciplinary field of mental health. By focusing on consumers' strengths and capabilities as well as on their symptoms, social workers can counter the **stigma**, or discredit, that occurs when the individual's diagnosis becomes an enduring label. Many consumers and professionals have united to attack the labeling that is still common in the mental health field and unthinkable in other areas. Bjorklund (1996) points out that people diagnosed with schizophrenia are called schizophrenics, but people diagnosed with cancer are never called "cancerics." Social workers can help in this social justice effort by being attentive to the use of language.

A strengths perspective allows social workers to view the whole person, not just the mental illness. By assessing areas of strength, the social worker can identify ways to help. For example, a consumer who has learned to structure his or her environment to maintain control over psychiatric symptoms might do well in a volunteer or paid position that requires creating a structured environment, such as organizing and overseeing a waiting room or keeping careful records of donations to a nonprofit agency.

The strengths perspective can help the social worker maintain hope and appreciation for the many acts of heroism involved in day-to-day living with

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long-term mental illnesses. By looking for strengths, social workers can identify the many ways that consumers are already attempting to cope with their conditions and can view consumers as partners in the treatment process rather than as individuals whose deficits overwhelm their lives (See Boxes 10.4 and 10.5).

Box 10.4 From the Field

Working with People Living with Serious Mental Illness Robert Bjorklund, LICSW, MSW, MPA

After completing my graduate social work education, I was deeply committed to seeking innovative ways to enhance the lives of people living with serious mental illness. The direct practice experience I gained in both community and inpatient settings has been integral to my current position as a state mental health program administrator. I oversee the statewide implementation of an evidence-based practice model called Program of Assertive Community Treatment (PACT), which is a research-proven program providing intensive community supports for individuals living with serious mental illness. Possessing a solid clinical understanding of mental health treatment issues greatly enhances my ability to effectively implement such a major program serving up to 800 people throughout the state of Washington.

PACT teams are multidisciplinary, with bachelor's- and master's-level social workers playing integral roles and interacting as equals with all team members, including psychiatrists. The teams address the entire range of needs for individuals with serious mental illness through the provision of a broad range of services. The emphasis is on providing individualized and intensive outreach-oriented services, the majority of which are provided in the community. Services provided by PACT team members include mental health, assistance with chemical dependency, vocational, and housing assistance among others. Priority is given to individuals diagnosed with schizophrenia, bipolar disorder, and co-occurring substance abuse disorders, among other diagnoses. These individuals have a high use of psychiatric hospitalization and crisis services, have difficulty benefiting from traditional services, and may have a high risk or history of arrest and incarceration. Without the intensive community supports provided by committed PACT team members 24 hours a day, seven days a week, most individuals would most likely be rehospitalized, incarcerated, on the streets, *or worse*! It has been gratifying for me to see, firsthand, how individuals and their families have been positively impacted and are on a path to living a far more rewarding and productive life than what their original prognosis had predicted.

A highly rewarding aspect of my varied social work roles, especially in my current administrative position, is to directly contribute to a statewide recovery culture in the mental health field. The concept of recovery has been a major paradigm shift occurring across the country for over the past decade. I am proud to say I was practicing recovery well before it became an operationalized term in the mental health field. My social work education had prepared me for working from a strengths-based perspective, using people-first language, utilizing an ecological systems framework, and fostering the concepts of self-determination and empowerment—all of which *are* recovery!

One of my supplemental professional roles is providing clinical supervision to social work licensure candidates pursuing clinical licensure, which allows me to stay current on mental health employment trends. Without doubt, the social work degree is preferred by the majority of public and private social service agencies. It is highly advisable that you investigate your state's specific licensing requirements well before you graduate so that you are clear on the requirements for earning your license (some states have baccalaureate-level licensure requirements, and every state has master's-level licensure or certification requirements). Clinical licensure, although required for many direct practice positions, is increasingly required for supervisory and administrative positions. Your marketability and professional credibility are greatly enhanced by possessing a social work license. In my prior position as clinical director of a licensed community mental health agency, it was a requirement that I had my LICSW so I could supervise licensed staff, conduct assessments and mental health evaluations, and bill for Medicaid services.

For far too long, individuals with serious mental illness have been viewed and treated based on their *perceived* deficiencies rather than their many unrecognized and underdeveloped strengths. Social workers are uniquely trained to build on individual and family-system strengths, thereby helping to change the unfortunate (and outdated) carryover of the medical model's shortsighted views of mental illness.

(continued)