June/July 2011

The "Immigrant Experience" of Assimilation for People with Behavioral Health Diagnoses

By Susan Grider Montgomery, MBA, PMP - Behavioral Health Consumer Since 1985

June 10, 2011 – Cover Note to SVHE Annual Conference Attendees:

This cover note is to inform participants at the 2011 Annual Conference of the Society for Values (SVHE) in Higher Education in Elmhurst, Illinois of intended next steps for this document. I have forwarded this paper to leadership at the National Alliance on Mental Illness (NAMI).

My goal is to extend the life of the document by publishing the article in part or in full with The NAMI Advocate. Other possibilities include working with NAMI regarding development of a "Graduated Re-Entry Program." Such a Program would allow a behavioral health consumer coming out of a hospital situation to re-enter the workforce on a gradual level. This schedule might start at 20 hours a week and increase to 30 or 40 hours a week as best fits the health profile of the person involved. Support at NAMI for such a "Graduated Re-Entry Program" might include financial underwriting of the part-time week schedule. Or support at NAMI may include getting public sector buy-in for this concept either at the programmatic or financial level.

Thank you for your interest and/or support!

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I. Introduction: Immigration, Behavioral Health and "Outsidership"

This paper seeks to pursue immigration as a metaphor for similar acculturation concerns of a virtually "untalked about" minority population in the United States – people with behavioral health diagnoses. The attributes of the Posse Foundation (often working with immigrant and/or underserved populations) will be reviewed for applicability to assimilation issues in higher education and in the workplace for people with behavioral health diagnoses[1]. In addition, challenges into the future for both those of immigrant heritage and with behavioral health diagnoses will be discussed.

In the discussion, reference will be made to African Americans as an immigrant population. This most directly includes those people whose parents migrated in the recent past to the United States from African countries. The concept of "outsidership" may be applied to those African Americans with immediate (at the parent level) African heritage as well as extended to "Black Americans" (defined here as people with African heritage from multiple generations back). These Black Americans, it is believed, may still be dealing with "immigration concerns" associated with their migration generations back into United States' society due to the historical practice of slavery and its termination after the Civil War.

II. Attributes of the Posse Foundation and Its Applicability to People with Behavioral Health Diagnoses

First, here are some facts about The Posse Foundation:

1) "Since 1989, The Posse Foundation has identified, recruited and trained 3,148 public high school students with extraordinary academic and leadership potential to become Posse Scholars. These students—many of whom might have been overlooked by traditional college selection processes—receive four-year, full-tuition leadership scholarships from Posse's partner institutions of higher education.[2]"
2) "Posse Scholars graduate at a rate of 90 percent and make a visible difference on campus and throughout their professional careers.[3]"
3) "Posse extends to these students the opportunity to pursue personal and academic excellence by placing them in supportive, multicultural teams—Posses—of 10 students.[4]"

[1] May include depression, bipolar illness, anxiety disorders, schizophrenia, addiction disorders, etc.
[2] http://www.possefoundation.org/ 1/28/11; (Hereafter cited as "Posse.")
[3] Posse.

Consider the application of Posse attributes to immigrant/underserved populations' and to behavioral health patients' assimilations to society:

1) Support teams are critical when the need to assimilate to the norm is high.
2) Support teams are critical in overcoming stigma and/or profiling of immigrant or outsider populations.
3) Rigorous laws are needed to protect outsider populations including behavioral health patients.
4) Some financial sponsorship is expected when assisting outsider populations including behavioral health patients.
5) Assimilation to the norm should not require duplicate goal structures.
6) Tailoring goals to the population subset may allow the greatest (and least costly) contribution to society.

III. Similarities in Goal Structures for Immigrants and Behavioral Health Consumers

Values of a Support or Peer Team in Practicing Assimilation: An immigrant is more likely to maneuver assimilation concerns if s/he has a support system. The same is true for behavioral health patients. Peer groups and group therapy make the task of self-examination and health recovery more manageable perhaps because these mechanisms are more social in nature.

Reversing Stigma and the Core Including the Family: When people do not talk openly about their behavioral health concerns and/or their difficulties assimilating to societal norms, stigma carries more weight and may fester and grow. Lack of sharing regarding mental health may even be experienced in the family unit. Rather than talking about symptoms, medications and healthcare, people can be stunted by shame and embarrassment. This lack of dialogue serves to exacerbate the illness by adding to feelings of isolation. In addition, the media adds to illness-based profiling each time a criminal act involves someone who is mentally unstable.

[4] http://www.possefoundation.org/about-posse/ 1/28/11.

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Getting Clarity about ADA Laws is needed: The laws addressing race and ethnic profiling (i.e. hate crimes and others) are clear as are the laws of the Americans with Disabilities Act. The laws' clarity however does not guarantee widespread adherence to them. Maneuvering through ADA laws in the workplace or at school may be difficult. It may take a person 24 to 36 months or more (the current timeframe for filing a complaint is one year) to overcome the emotional trauma associated with an ADA breach, thus leaving no legal outlet for voicing grievances.

Financial Assistance Can Be Put to Better Use than Just Increasing Hospital Budgets. The need in the US for a graduated re-entry program in behavioral health along the Posse model is tremendous. While the Posse Program may assist immigrants and/or "outsiders" with challenges in higher education, similar posse support systems are needed for those with behavioral health diagnoses. A graduated re-entry program for behavioral health patients might be seen as the equivalent to the development of minority-run businesses in Chinatowns across the US. A graduated re-entry model would probably be less costly that the current formula of providing acute care in hospitals (and/or jails) and then releasing the patient with little follow-through. It is possible that the number of patients needing acute care/hospitalization (or incarceration) would be greatly reduced if the US were to develop such a program.

A Graduated Reentry Program to School and/or Jobs Demonstrates a Relevant Goal Structure for Behavioral Health Parties. Currently, the pressure rests on the individual to maneuver through red tape at university or job surrounding reentry after a "break." Often this reentry is contingent upon how supportive the instructor or boss is.

Adopting a goal framework that is relevant to behavioral health challenges is critical. Most behavioral health patients have difficulty managing the stresses of a 40 to 60-hour-a-week job or completing an undergraduate/graduate program in the specified timeframe. Perhaps a more reasonable goal would be working a 25 to 35-per-hour-week with scalable benefits and/or allowances for a longer than the norm matriculation time. This type of program would encourage people with behavioral health concerns to make a contribution to society *on their own terms.* Rather than expecting patients to manage an extended work week or rigorous school schedule and still maintain their health, a 30 hour work week or reduced course load becomes the goal. The residual 10 hours or time free from scholastic activities then becomes dedicated to health maintenance work such as med management, therapy, 12-step meetings, and healthy eating/exercise. This 10 hour health maintenance or extended matriculation schedule could

be financed by the private sector much as the Posse Foundation finances student scholarships. The results of such a program may be as rich and varied as the societal contributions of "Chinatowns" and their equivalents across US inner cities.

The Graduated Re-entry Model May Have Fiscal as Well as Health Merits*:* The cost of a graduated re-entry program in behavioral health begs further analysis. The US might cut its behavioral health hospitalization and incarceration costs in half by developing such a graduated re-entry program. Or, it may be that the cost savings associated with such a program are sufficient to finance its start-up.

IV. Common Challenges into the Future for Immigrants and Behavioral Health Consumers

In summation, I would like to suggest that there are common areas of concern in the challenges ahead of assimilation whether that assimilation is associated with immigration issues or with a behavioral health diagnosis. These commonalities include:

1) ***The Multiplier Effect of Vocal Leadership*** – There is a multiplier effect when individuals dealing with immigration concerns or behavioral health concerns speak out and speak up. When such leaders are engaged, they are not only speaking up and speaking out for their own struggles with immigration or behavioral health concerns, they are speaking up and speaking out for all those people who are similarly "labeled" for example as Chinese or as Bipolar.

   When Gary Locke, the first Chinese-American to hold the office of the Secretary of the Department of Commerce[5], speaks out for DOC concerns, he is speaking for America but he is also more specifically speaking out for Chinese-Americans at every level in the United States economy. When Catherine Zeta-Jones (the actress) allows the press to feature an article on her

[5] http://www.commerce.gov/about-commerce/commerce-leadership/secretary-gary-locke.

struggles with bipolar illness[6], she is not only educating the public about her illness, she is speaking out for all women and men who may be challenged with the diagnosis of bipolar illness.

2) ***Residual Stigma*** – As stigma associated with being an "outsider" whether by ethnicity or behavioral health diagnosis is addressed, it is easy to begin to think that stigma in the general population has been conquered. While great strides are being made to address the stigma of a specific ethnic origin or a specific behavioral health diagnosis, stigma still continues. To say that President Obama's term as President has greatly reduced the stigma of being an African American or of being from African ancestry (Black American as defined here) in the United States is certainly true. However, by no means has the stigma of being "black" in America been expunged.

   As actress Glenn Close speaks up about bipolar illness and its challenges in her family, she is working to reduce stigma[7]. However important this work may be, it still does not guarantee the eradication of stigma associated with a behavioral health diagnosis. Like many societal factors, stigma may itself ebb and flow depending on the role models in positions of power and their efforts to combat prejudice.

3) ***Legacy Concerns*** – Perhaps one of the most salient concerns for people of immigrant heritage and people with behavioral health diagnoses is the question of what to tell our children. If the struggle of one generation does not inform the struggles of the next generation, our collective stories become fragmented and lose their inspiration. So it is important for the older generation to share their struggles and their successes with the next generation. However, there is probably

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[6] **Catherine Zeta-Jones: 'There Is No Need to Suffer Silently' http://www.people.com/people/article/0,,20483309,00.html**

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[7] NAMI Advocate e-newsletter, November 2009 "**Actress Glenn Close is Changing Minds about Mental Illness and more:" http://www.nami.org/ADVTemplate.cfm?Section=Advocate_Magazine&template=/ContentManagement/ContentDisplay.cfm&ContentID=89806 and also "Actress Glenn Close's Anti-Stigma Campaign Joins NAMIWalks Raising Funds for Hope and Recovery from Mental Illness - April 1, 2010:" http://www.nami.org/Template.cfm?Section=press_room&template=/ContentManagement/ContentDisplay.cfm&ContentID=97421.**

a much needed balance in the sharing. Too much emphasis on "the past" and prejudicial treatment in the past may become the burden for current and future generations. The goal is to be sure stories of the past involving stigma and prejudice are shared but shared in such a light as to inspire further progress in addressing those concerns. Current Secretary of Labor Hilda L. Solis (Latina American) in the Obama Administration has a very impressive service record in government work in both California and the US governments with service beginning as early as the Carter Administration.[8] The most relevant question may be what part of her history does she share with the children in her family. Does she share only her successes as a way to inspire youth or does she also share the failures and the set-backs?

In my own family I have chosen to share my history of bipolar illness with my daughter who is seven. She is aware that Mom has an illness and seeks regular assistance from the medical community in managing that illness. While I seek to educate her on what to look for in the illness, I by no means share with her the full "dark days" associated with it. Further what I chose to share with her as she grows older and matures will likely change.

4) ***Assimilation versus like peer groups*** – Perhaps one of the most difficult hurdles to tackle when you are an "outsider" is how to go about the business of making friends and contacts in the working world, at places of worship, in the neighborhood, and/or in recreational settings. As an "outsider" I may gain an extra boost of self-confidence by developing the majority of my friendships with "insiders." I may seek to make my racial or ethnic or health profile to be as invisible as possible by aligning myself professionally, socially or spiritually with people who are "not like me." I may spend years seeking to prove to myself and to society that I am not an "outsider." The composition of my peer group at work, at school, at church or at the swimming club may represent an effort to "white wash" if you will my ethnic or behavioral health history. I may tell myself "If I can keep up with 'the Joneses' then perhaps I am no longer considered an 'outsider' by myself or others."

On the other hand, the need for peer affirmation for "outsiders" by ethnicity/race or mental health diagnosis also runs very deep. The pull to keep one's roots deep in our communities of origin be that ethnic/racial origin or behavioral health origin is strong for "outsiders" of any ilk. By keeping

[8] http://www.dol.gov/_sec/welcome.htm

these ties strong we may provide ourselves much needed affirmations – daily, weekly, monthly and yearly -- as well as spiritual bolstering that otherwise would be lost if we were to find ourselves "assimilating 24 by 7."

I have witnessed the tension between assimilation and peer immersion since I was a college student at Dartmouth College. In what was then a largely traditional student population, I witnessed those of different racial or ethnic heritage working a dual action plan of social development both inside and outside their identity of origin. This equates to some sort of fluency in general sociality as well as fluency in one's own ethnicity of origin. As I have developed my own social ties over the years, I have also noted in myself this need for dual fluency in my social circles including assimilating to societal norms as well as retreating to deep-seated ties to peers in my behavioral health support circles.

V. Summary and Closure

Perhaps the goal for all those who find themselves to be "outsiders" in one way or another is to develop strong relationships both inside and outside of our communities of origin. Perhaps we need to be reminded on a regular basis by our peer groups of how far we have come in addressing stigma and prejudice. At the same time, we need to develop relationships outside of our ethnicities/racial heritage or mental health diagnoses so that we may continue to make inroads into new areas of success in society be that our successes in educational endeavors, work accomplishments, spiritual or religious advances and/or civil society contributions.

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