Racial and Ethnic Disparities in Pediatric Mental Health

Margarita Alegria, PhD[a,b,*], Melissa Vallas, MD[c], Andres J. Pumariega, MD[d]

KEYWORDS

• Ethnic • Racial • Disparities • Youth • Mental health • Minorities • Health care

Despite the enormous toll that mental health problems take on the well-being of youth and families ($247 billion annually)[1] disparities in access to and intensity of quality mental health services appear to persist for racial/ethnic minority children, who are more likely to receive fewer and inferior health services than their non-Latino white peers.[2] This fact has raised serious questions about the progress made in reducing disparities, even though it has been an explicit focus of public health surveillance since 2000, and continues to be monitored as part of the National Healthcare Disparities Report.[3] This article discusses the current state of disparities in pediatric mental health care, underlining the challenges and potential obstacles to successfully addressing these disparities. The authors first make explicit their definition of "disparity," then proceed to describe disparities as they exist in diagnostic assessment, prevention of mental health problems, need for mental health care, access to services, psychotherapy, pharmacologic treatments, and outcomes of care. The article concludes with necessary approaches and specific recommendations.

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[a] Department of Psychiatry, Harvard Medical School, MA, USA
[b] Center for Multicultural Mental Health Research, Cambridge Health Alliance, 120 Beacon Street, Fourth Floor, Somerville, MA 02143, USA
[c] Division of Child & Adolescent Psychiatry, Lucile Packard Children's Hospital at Stanford, 401 Quarry Road, Stanford, CA 94305-5719, USA
[d] Section of Child and Adolescent Psychiatry, The Reading Hospital and Medical Center, Temple University School of Medicine, Sixth Avenue and Spruce Street, Reading, PA 19612, USA
* Corresponding author. Center for Multicultural Research, Cambridge Health Alliance, 120 Beacon Street, Fourth Floor, Somerville, MA 02143, USA
E-mail address: malegria@charesearch.org

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DEFINING DISPARITIES

In the face of the health disparities debate, several definitions have been used for the term "disparity." The definition provided by the National Institute of Medicine[2] describes a health service disparity as "differences in treatment or access not justified by the differences in health status or preferences of the groups." This statement implies that although differences between racial/ethnic groups in service use might be explained by several factors related to need for health care services (eg, differences in parental recognition of a child's need or divergent pathways into care between groups), only the remainder of the identified difference *after* adjusting for the mental health profile is defined as the *disparity*. The Institute of Medicine definition also posits that racial/ethnic disparities are unfair and worthy of remediation, even if they arise through racial/ethnic differences in socioeconomic status, insurance, or other mechanisms outside of need and preferences.[4] With that definition of disparity in mind, there has been not only a distinct body of literature that describes disparities in mental health care in racial and ethnic minority children, and in families of lower socioeconomic status, but it has also become increasingly apparent that ethnic/racial minority children are underserved relative to their non-Latino white counterparts in the areas of prevention, access, quality treatments, and outcomes of care. In this article, the authors summarize these important findings and provide recommendations for promising targets to reduce disparities.

PREVENTION OF MENTAL HEALTH PROBLEMS

The presence of psychiatric disorders in childhood has been linked to negative outcomes, including poor social mobility and reduced social capital. For example, childhood depression has been associated with increased welfare dependence and unemployment.[5] Many of these identifiable risk factors for mental illness disproportionately affect minority children, such as poverty, food insecurity, and exposure to violence, increasing the likelihood that ethnic/racial minority children are actually included in many preventive interventions. According to the United States Census, in 2007 approximately 18.0% of children were poor, and among these, black and Latino children were disproportionately affected.[6] Beiser[7] has shown how economic difficulties seriously affect the likelihood of psychiatric disorders in youth.

High rates of isolation and socioeconomic disadvantage of minority children can have significant adverse effects on children's mental health, including depression and behavior problems,[8] anxiety disorders such as posttraumatic stress disorder,[9] and a range of other adjustment difficulties. Food insecurity, or uncertain availability of food because of inadequate resources, is one of the many difficulties associated with poverty. Like poverty, risk of food insecurity is also patterned by race/ethnicity.[10] Many ethnic and racial minority children and adolescents also experience "compounded community trauma," which has been defined as the experience of children when they witness violence in *both* their homes and their neighborhoods.[11] Compounded community trauma has been linked to high rates of mental illness, including posttraumatic stress disorder, depression, and externalizing behaviors.[11,12] Additional factors that increase the risk for mental illness for minority youth are neighborhood exposure to violence,[13] neighborhood social disorganization,[14] repeated experiences of discrimination, and chronic exposure to racism.[15] As a result, early interventions in the lives of ethnic and racial minority children, intended to maximize their effective coping in these disadvantaged and at-risk environments, can be advantageous in terms of future outcomes.[1] Thus, effective service delivery systems that engage in

early prevention and intervention are essential to reduce the burden of mental disorders for ethnic and racial minorities.[16]

Bayer and colleagues[17] have examined about 50 preventive interventions that have been evaluated in randomized controlled trials, most of which targeted children's behavioral problems. These investigators cite several United States programs for their robust evidence of efficacious outcomes. In infancy, the individual Nurse Home Visitation Program,[18] which provided individual home visits for mostly ethnic and racial minority, first-time mothers who screened as single or low income, showed efficacy in decreasing child abuse and adolescent delinquency at a 15-year follow up. During preschool age, Triple P[19] and Incredible Years[20] are the most widely known and respected preventive interventions for child behavior problems. Both programs are geared toward parents with children identified as already having behavior problems. Both indicated efficacy in decreasing behavior problems, and in improving parenting practices and mental health. The individual Family Check-Up Program[21] also provided brief family support offered to at-risk families in the home or in community centers, and was shown to be effective in promoting proactive and positive parenting skills that correlated with changes in children's disruptive behavior. For school-age children, the John Hopkins Prevention program,[22] a 1-year program for first graders in high-risk school settings, showed a decrease in teacher reports of problem behaviors, conduct disorder diagnosis at sixth grade, school suspension, special classroom placement, and medication. Lastly, the Good Behavior Game class program[23] was a 2-year whole school social skills curriculum that showed efficacy in improved attention and concentration, and less oppositional and conduct behavior problems, predominantly in children with moderate levels of initial inattention.[17] Most of these preventive measures in very young children have focused on parenting interventions, and have targeted children who have been identified either as being at risk or as already having behavior problems. These programs all show promise of minimizing the negative effects of at-risk environments and appear to effectively work for ethnic and racial minority youth.

In older children, prevention programs have focused directly on those children identified as having behavior problems, and have also included interventions with parents. One large study done in the United States was instrumental in providing evidence for the importance of available funding for preschools in urban areas. In 2001, Reynolds and colleagues.[24] found that in a large group of predominantly black urban children, preschool participation was associated with a notably higher rate of school completion, significantly lower rates of juvenile arrest, and lower rates of special education and grade retention by late adolescence.[24]

Although there are several well-researched early prevention interventions that have proved to be effective in reducing behavior problems in ethnic and racial minority children, most interventions target externalizing behavior (such as attention-deficit disorder or oppositional defiant disorder), with limited research geared toward interventions that tackle internalizing disorders (such as depression or some anxiety disorders). Exceptions are Kataoka's Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), which effectively addresses traumatic stress in diverse communities,[25] and the study by Weisz and colleagues[26] in 2005. Kataoka and colleagues tested an intervention with third through eighth grade students with trauma-related depression and/or posttraumatic stress disorder symptoms, in which group cognitive-behavioral therapy was delivered in Spanish by bilingual, bicultural school social workers, with additional psychoeducation and support services available for parents and teachers. Students in the intervention groups showed significantly greater improvement than those placed on a waitlist for the program. Other community-based

interventions that show promise include school-based services, mentoring programs, family support and education programs, and wilderness programs. Many of these have demonstrated effectiveness with African American, Latino, and American Indian children and families.[27] School-based prevention efforts such as those already mentioned have demonstrated positive outcomes when adaptations are done with a specific cultural context in mind, such as The Circles of Care, which are specially focused on the needs of American Indian children and youth.[28]

NEED FOR MENTAL HEALTH SERVICES

Mental health need is significantly higher amongst at-risk groups of children and youth, a group that is overwhelmingly of ethnic and racial minority background. Several studies have documented high rates of serious emotional disturbance amongst youth in the juvenile justice system[29] and in the child welfare system (rates of 50%). These systems also comprise high percentages (50%–70%) of underserved minority youth, principally African Americans, Latinos, and American Indians.[30] Many youth with mental disorders are typically referred to juvenile justice if they display aggressive or disruptive behaviors,[31] without consideration of whether these are untreated mental health problems.[32] There has also been increasing recognition that children in the child welfare system have extremely high mental health needs,[30] with prevalence rates estimated at close to 50%. However, they are significantly underserved with respect to mental health services, partly due to a shortage of mental health providers to address their needs. Minority children and youth experience higher rates of entry into juvenile justice and child welfare.[30,33]

Another less recognized, high-risk population is children of women who have experienced maternal depression. Longitudinal research has demonstrated the long-term impact on children of maternal depression, including estimated prevalence rates of emotional or behavioral disturbance of 50% to 80%, with increased risk for depression, separation anxiety, attention deficits, and conduct disturbances.[34] In addition, the rates of postpartum and maternal depression amongst underserved racial/ethnic minority groups are as high as 30% to 40%.[34]

Amongst minority populations, some studies have suggested higher population prevalence of psychiatric disorders such as depression, anxiety disorders, substance abuse, and even eating disorders.[35] For example, the Youth Risk Behavior Survey of the Centers for Disease Control found significant higher prevalence rates of sad mood, suicidal ideation, and suicidal attempts amongst Latino and African American youth as compared with non-Hispanic whites.[36] In terms of the abuse of illicit drugs, Latino youth have equal rates to whites, but higher rates than African Americans.[37]

DIAGNOSTIC ASSESSMENT

Significant diagnostic disparities have been documented in children's mental health, largely with African American and Latino children.[35,38,39] Similarly, the conceptual equivalence in the terminology of screening/diagnostic measures[40,41] may influence proper identification of minority cases in need for treatment. There is some evidence that the way in which questions are phrased may lead to response bias by minority youth, in that they may differentially endorse screener items compared with white youth with similar clinical profiles. Diagnostic disparities have also been associated with regional differences in the representation of minority populations.[42] In addition, significant delays have been identified in the diagnosis of autism in African American (7.9 years) versus white children (6.3 years).[43]

ACCESS TO FORMAL MENTAL HEALTH SERVICES

As evidence of racial and ethnic disparities in mental health care access continues to increase, efforts have been made to better understand gaps and limitations in the way that minority children's mental health services are provided. In the last 3 decades, there have been increased efforts to raise awareness of the need for comprehensive, community-based, child-centered, and culturally competent mental health care for children,[44] particularly ethnic and racial minority children. Developing appropriate health and mental health treatment services for ethnic minorities requires comprehensive and ongoing collaborative efforts that address issues of nonengagement in mental health treatments, such as cultural differences in the perception of illness and its causes, help-seeking behavior and attitude toward health care providers, and in how ethnic and racial minority families prioritize, respond to, and adhere to mental health treatments.[45] Caregivers of minority youth might have perceptions that can affect referral to professional treatment, leading to different help-seeking behaviors and underrecognition of mental health problems.[46–50] At the same time, a wide range of structural and sociopolitical constraints related to accessing services disproportionately affect minority youth, such as poverty, lack of insurance, and insufficient availability of behavioral health services in minority neighborhoods. Latino children, for example, have the lowest rate of public or private health insurance coverage of any ethnic group (37%), nearly half that of whites.[51] This factor is particularly critical when addressing the needs of minority children.

According to the Institute of Medicine Report,[1] minority youth are less likely to receive mental health care services than their non-Latino white counterparts. Kodjo and Auinger[52] analyzed the National Longitudinal Study of Adolescent Health (2003) and found that African American but not Latino youth were significantly less likely than non-Latino white youth to have received psychological counseling. Analyzing 3 nationally representative household surveys, Kataoka and colleagues[9] found that both African American and Latino youth had lower rates of mental health service use than their non-Latino white counterparts. Among regional studies, those by McCabe and colleagues,[53] Bui and Takeuchi,[54] and Sue and colleagues[55] found white and black youth to be overrepresented and Latino youth underrepresented across most treatment sectors, while Zahner and Daskalakis[56] found that black and Latino youth underuse services, after controlling for socioeconomic status. Cuffe and colleagues[31] found African American females much less likely to receive mental health services. Overall, the evidence seems to suggest that minority children have the highest rates of unmet need for mental health services.[57,58]

Even when they are able to access care, minorities are significantly undertreated compared with their white counterparts,[57,59] with linguistic minorities reporting worse care than English-speaking racial and ethnic minorities.[60] At the same time, there have been vast increases in the number of school-age children in the United States who do not speak English well, or who are from families in which the adults do not speak English proficiently. In the last projections of the Census, about 26.3% of children aged 5 to 17 years reported that they speak English worse than "very well,"[61] and about 19.7% of children live in linguistically isolated households where all household members older than 14 years have limited English proficiency.[62] This finding suggests that there might be great challenges in achieving equitable mental health care for ethnic and racial minority children in the United States, especially linguistic minorities.

Some studies have shown that most children with mental illnesses do not receive specialty mental health services, but that ethnic and racial minorities are at a more serious disadvantage.[9] Not surprisingly, poor and minority youth, despite equal if not higher need for services, often receive lower quantity and quality of mental health services. Indeed, one could infer a "greater burden of disease" in children, especially poor and minority children, if they are less likely to receive treatment for their illnesses, or receive poorer quality of treatment.[63]

PSYCHOTHERAPY AND ETHNIC AND RACIAL DISPARITIES

Psychotherapy is considered to be an evidence-based treatment for most major mental disorders. In fact, patients who receive both psychopharmacologic treatment and psychotherapy have better outcomes of treatment than do patients receiving only psychopharmacologic treatment, among those with numerous mental illnesses.[64] However, despite its importance as a treatment modality for mental illness, there remain disparities in psychotherapy's utility among ethnic minorities, and limited well-established, effective treatments for ethnic minority youth.[65] In a sample of children enrolled in the child welfare system, counseling access was found to be lower for African American children than for white children. The study also found that both private health insurance and a lack of insurance were negatively associated with counseling access, whereas a history of sexual abuse and greater caseworker efforts to secure services were positively associated with access.[66]

Despite the data suggesting that minorities are less likely to receive psychotherapy for mental illness, there are studies confirming that minority children can benefit from community-based psychotherapy. For example, one study demonstrated a successful implementation of a brief psychosocial intervention (individual psychotherapy) delivered by community-based clinicians in urban school-based health clinics serving minority students with depression.[67] Others have looked beyond the issue of disparity, and focused more on intervention efficacy by attempting to recognize evidence-based treatments geared specifically to minority youth. Community-based treatment of adolescents with substance abuse disorders is both accessible and efficacious, with considerable evidence for day treatment, night programs, and school-based programs. Few such community-based programs and treatment modalities are designed to treat the special needs of females, minority groups, and medically compromised individuals such as those with AIDS, but recent progress is being made in adopting the principles of cultural competence in the treatment of adolescent substance abuse disorders. Brief Strategic Family Therapy, an evidence-based family intervention, has been developed and tested with Latino and African American youth.[68] Ethnically specific programs for American Indian youth based on traditional values and rituals/ceremonies have also been developed and evaluated.[69,70]

Huey and Polo[65] reviewed research on evidence-based treatments for this population (ages 18 and younger), and found no well-established treatments defined as requiring at least 2 high-quality (eg, random assignment, adequate sample size) between-group trials by different investigative teams showing that treatment is superior to placebo or another treatment, or equivalent to an already established treatment. However, they were able to identify probably efficacious treatments for ethnic minority youth with anxiety-related problems, attention-deficit/hyperactivity disorder [ADHD], depression, conduct problems, substance use problems, trauma-related syndromes, and other clinical problems. Huey and Polo defined "probably efficacious treatments" as those that require only one high-quality trial comparing treatment to placebo (or alternative treatment) or 2 trials comparing treatment to no treatment.

PSYCHOPHARMACOLOGIC TREATMENTS

There is growing evidence that psychotropic prescribing frequency in child psychiatry continues to increase around the world, with stimulants, selective serotonin reuptake inhibitors (SSRIs), and antipsychotics being the most commonly prescribed.[71] The United States in particular is accountable for more than 80% of the world's use of stimulant medication. In addition, antidepressants and antipsychotics are much more frequently prescribed to children and adolescents in the United States than in most other industrialized countries.[72] However, despite the prevalent use of psychotropic prescription drugs in children and adolescents in this country, there continues to be concern that there are differences in prescription psychotropic drug use based on race and ethnicity. Treatment disparities include lower use of psychiatric pharmacotherapy, with significantly lower use amongst African Americans and Latinos,[73,74] higher rates of treatment noncompletion, and higher likelihood of receiving inadequate treatment.[75]

The adult literature has produced consistent findings suggesting that race is an independent predictor of mental health service use, and prescription drug use in particular, in a wide array of mental illnesses.[76] Race and ethnic disparities in psychotropic drug use in children has been studied in several samples: children enrolled in Medicaid, special education students, public school students, participants in the National Ambulatory Medical Survey (NAMCS), and high-risk children participating in the Patterns of Youth Mental Health Care in Public Service Systems (POC). In all studies, white children were at least 2 times more likely, if not more so, to receive psychotropic medication than nonwhite children. For example, Bussing and colleagues[77] found that in a special education population, minority children at risk for ADHD were twice as likely than nonwhite children to not receive stimulant medication. Also, Lasser and colleagues[78] found that in adolescents, visit rates per year to primary care providers or psychiatrists for mental health services were much lower for African Americans relative to whites for the same services, including psychotropic medication prescription. Similar findings have been seen in a sample of children aged 5 through 14 years enrolled in state Medicaid programs. African American children showed a distinctly lower rate of treatment with psychopharmacologic agents.[79] In the specific sample of high-risk youth who were participants in the Patterns of Care study[57] where the prevalence of psychotropic medication use was as high as 54%, minority race/ethnicity was associated with lower use of psychotropic medication, adjusting for factors such as age, gender, income, insurance status, need, or impairment. In this study, both African American and Latino youth had a reduced likelihood of using psychotropic medications after controlling for other factors.[73]

Several unanswered questions remain about the reasons for such disparity in the areas of both psychopharmacology treatment and use of psychotherapy as a treatment for mental illness in children. Many have postulated that there are several sociocultural issues that play a role in not only the initiation but also the continuation of mental health treatment.[72] Specifically, minority youth face several barriers to effective mental health care that have been defined in the literature; these include population barriers (socioeconomic disparities, stigma, poor health education, lack of activism), provider factors (deficits in cross-cultural knowledge, skills, patient orientation, and attitudinal sensitivity), and systemic factors (services location and organization, training, culturally competent services, and so forth).[35] There is a large body of literature recognizing the deficits in our mental health care system that negatively and disproportionately affect minority children.[80] Future research should lend itself to better understanding the barriers that perpetuate such dysfunction, as well as finding innovative and efficacious ways to combat them.

OUTCOMES OF TREATMENT

Few studies have compared racial/ethnic differences in the outcomes from mental health treatment. In studies of mainstream interventions, only 2 studies found ethnic minority children do not respond as well as white youth with similar characteristics. The Multi-site Treatment Study of Attention Deficit and Hyperactivity Disorders found that inner-city Latino and African American youth had higher levels of symptoms following pharmacotherapy, and required combination pharmacotherapy and behavioral therapy for equal response to whites.[81] However, these differences were not significant once socioeconomic disadvantage was taken into account. Another study found poorer outcomes in preventing depression in African American youth compared with white, Latino, and Asian youth in an intervention to increase optimism.[81]

Most studies find similar or improved outcomes of mental health treatment for ethnic and racial minority youth as for whites. One study examined cross-ethnic outcomes from public community mental health services in a California sample of youth. Asian American youth were found to improve significantly more on clinical and functional measures than youth of other ethnic/racial backgrounds, while parents reported them as having fewer problems at baseline.[82] In addition, there have been several community-based, evidence-based interventions that have demonstrated efficacy and effectiveness and are increasingly being implemented in child mental health programs. These interventions include intensive case management, therapeutic foster care, partial hospitalization, and intensive in-home wraparound interventions.

However, the literature in terms of differential outcomes of treatment remains sparse. Santisteban and colleagues[83] have outlined pressing issues in the transfer of empirically supported treatments in ethnic minority populations, specifically Latino youth. These issues include testing established treatments in specifically Latino samples both with and without elements of cultural competence in the treatment model. There may also be treatments that do not meet the stringent criteria of empirically supported treatment but that demonstrate an adequate balance of internal and external validity with ethnic and racial minority children, which should be evaluated for effectiveness and differential outcomes in comparison with those of their white counterparts.

APPROACHES TO ADDRESSING DISPARITIES

Several approaches are being used to improve the financing of children's mental health services at the Federal level, including the State Children's Health Insurance Program (SCHIP)[84] and Medicaid Expansion SCHIP (M-SCHIP) to expand children's health insurance coverage to uninsured children, and the Home and Community-Based Services (HCBS) waivers and the Tax Equity and Financial Responsibility Act (TEFRA) option under Medicaid. These expansions help prevent the entry of children into state custody as a result of lack of coverage for mental illness and emotional disturbances by funding children to be treated in the community, as long as the cost of that care does not exceed the estimated cost of institutional care. The Early Periodic Screening Detection and Treatment mandate also provides for states to deliver medically necessary mental health services for children covered by Medicaid who have a mental disorder identified as part of periodic screening, with some states using behavioral health screening tools.[84] In addition, the Affordable Care Act of 2010 (health care reform legislation) recently passed by Congress included sections addressing workforce shortages in child mental health disciplines through program grant support and payback for child mental health discipline graduates serving underserved communities. However, there is a great deal to be done in both increasing the

diversity of the children's mental health workforce and the training of all children's mental health professionals on delivering culturally competent services.

Community-based systems of care for children's mental health has been a service philosophy that has been increasingly promoted and adopted nationally to better address both access to care and effectiveness of services, including endorsement by the US Surgeon General. The key principles of community systems of care include: access to a comprehensive array of services; treatment individualized to the child's needs; treatment in the least restrictive environment possible; full use of family and community resources; full participation of families as partners in services planning and delivery; interagency coordination; the use of case management for services coordination; no ejection or rejection from services due to lack of "treatability" or "cooperation"; early identification and intervention; smooth transition of youth into the adult service system; effective advocacy efforts; and nondiscriminating, culturally competent services. Community systems of care promote a flexible and individualized approach to service delivery for the child and family within the context of his or her home and community as an alternative to treatment in out-of-home settings, while attending to family and systems issues that affect such care. These factors include access, use, child and family empowerment, financing, and clinical- and cost-effectiveness of mental health services provided to children and adolescents, as well as the functioning and effectiveness of systems of care for child mental health.[27]

The Center for Mental Health Services (CMHS) Comprehensive Community Mental Health Services Program for Children and Their Families has funded more than 100 systems of care projects in diverse communities throughout the nation. The current phase of the grant program emphasizes culturally diverse populations and early childhood grants. The multisite national evaluation of the Comprehensive Mental Health Services Program for Children and Their Families has shown improved reduced out-of-home placements, improved school attendance, reduced service fragmentation, improved child and family functioning, reduced clinical symptoms, reduced family burdens, increased stability of living situation, and reduced cost of care when cost offsets in education, juvenile justice, child welfare, and general health are considered.[85] In addition, this program has demonstrated a significant reduction of racial/ethnic disparities in access to community mental health services, with 3 times the percentage of poor children, twice the percentage of African American children, and equal numbers of Latino children as in the populations of the targeted catchment areas.[86]

System of care integrated service strategies may include such activities as providing mental health consultation to Head Start, Early Intervention, primary care practitioners, community health nurses, and child care workers; and providing mental health services to adults whose children are at risk of out-of-home placement. States are also beginning to invest resources in training to improve the skills of early childhood clinicians.[34] Such approaches are even more critical for minority populations, which have a higher proportion of younger children and children at risk.

There are encouraging efforts toward enhancing and improving models of collaborative care between primary care and mental health providers. Some state Medicaid plans have adopted model or statewide programs to facilitate access to child mental health consultants by primary care practitioners, while others have invested in training for primary care practitioners on EPSDT (Early Periodic Screening, Diagnosis, and Treatment) tools, referral procedures, and consultative programs to enhance their function as mental health providers to high-risk populations.[84] Other more formal models of collaborative care, using such technologies as systematic screening tools

and telemedicine, are being evaluated and found to be effective in improving access to community-based care. More formal evaluation is needed on the use of nurse practitioners and physician's assistants as extenders in the delivery of child psychiatric services, as well as the use of culturally competent models of community outreach, such as Promotoras de Salud in minority communities.[27]

An increasing consensus exists for delivering mental health services for ethnic/racial minority populations within the cultural awareness framework. This framework indicates the need to identify and address the special mental health needs of diverse populations through both clinician-related factors (such as acquiring knowledge, skills, and attitudes that enable them to serve populations different from their own) and system factors (such as reviewing and changing policies and practices that present barriers to diverse populations, staff training around cultural competence, and the recruitment of diverse staff and clinicians for planning service pathways and delivering care). It also calls for the use of natural strengths and resources in concert with professional services that are protective and support children and families in diverse communities and cultures dealing with emotional disturbance. Cultural awareness and competence also includes the adoption of culturally specific therapeutic modalities (such as use of native healers or cultural mediators), mainstream modalities evaluated with diverse populations, and the appropriate use of language interpreters.[35]

The cultural competence framework has been operationalized in consensus health and mental health cultural competence standards, such as the CMHS standards. These standards address cultural adaptations and modifications in clinical processes (such as assessment, treatment planning, case management, and linguistic support) and system processes (such as staff training and development, access protocols, governance of service systems, quality assurance and improvement, and information management). There is initial evidence that adopting such practices results in improved access to services and retention in treatment. The CMHS Comprehensive Community Mental Health Services Program for Children and Their Families has promoted the cultural competence model, with improved outcomes for children and youth of minority backgrounds correlating with the application of cultural competence principles.

RECOMMENDATIONS

1. The government should name a Task Force to address the enormous gaps in unmet need for care for youth in general, and ethnic/racial minority youth in particular. The task force should evaluate whether changes in the current approach to the provision of mental health services are needed, including major changes in health care policy.
2. Evaluating the role of different sources of care (eg, schools and/or community agencies) in service delivery may help minority families become more receptive to mental health treatments. Designing programs, including after-school preventive programs, that address ethnic and racial minority families' competing demands and linguistic capacity, may help surmount barriers to mental health services.
3. Providing decision rules that help parents identify the threshold for labeling a problem requiring professional mental health care is essential. Health literacy, to understand the trade-offs in postponing early intervention for minority youth, may also prove helpful.
4. There is almost no literature on treatment preferences among minority youth and their families, underscoring the importance of developing such a line of inquiry. Aligning treatment options with what families of color value is necessary. Ensuring

that minority parents collaborate with providers so that their cultural values are considered is central to parental satisfaction and youth entry into mental health care.

5. Assessment instruments must provide accurate identification of symptoms and screening processes across ethnic and racial minority youth. More emphasis on the validity of diagnostic and screening instruments for minority populations is required of both service systems and researchers.
6. Different patterns of social and mental health problems might be associated with diagnostic uncertainty in minority youth, resulting in differential needs for treatment such as combined treatments or more case management services; more attention should be paid to differential needs of ethnic and racial minority families in assessment and treatment design.
7. To reduce disparities in access, allocation of outpatient mental health treatment resources in foster care and juvenile justice settings should be investigated to determine proper allocation of providers and adequate treatment capacity.
8. Negative attitudes, lack of treatment information, and financial concerns about treatment should be minimized by social marketing campaigns (to address stigma) or by financial coverage and treatment availability through SCHIP.
9. Given significantly lower treatment completion rates among African Americans and Latinos, interventions such as enhanced access to medications and "virtual" interventions (telephone, computers) that provide anonymity and are less burdensome to complete should be explored.
10. Interventions to reduce negative provider attitudes toward minority youth and enhance adoption of evidence-based treatment should be incentivized and supported in community health care systems. Building coaching teams that facilitate supervision and monitoring to train providers in evidence-based and culturally specific therapeutic modality treatments should be encouraged with financial and institutional support.

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