



Making Children's Mental Health Services Successful

Examining the Research Base Supporting Culturally Competent Children's Mental Health Services

A Monograph edited by

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Introduction & Overview

Hernandez, M., Nesman, T.,
Mowery, D., Gamache, P.

The purpose of this monograph is to present a description and analysis of the research literature related to child and family mental health among African Americans, Asian Americans/Pacific Islanders, Latinos, and Native Americans.

Background

Culturally and linguistically diverse children and families are a growing segment of the U.S. population that are currently underserved and/or inappropriately served in the mental health system (Alegría, Canino, Lai, Ramirez, Chavez, Rusch, & Shrout, 2004; Chow, Jaffee, & Snowden, 2003; Coard & Holden, 1998; Hough, Hazen, Soriano, Wood, McCabe, & Yeh, 2002; Kataoka, Zhang, & Wells, 2002; McCabe Yeh, Hough, Landsverk, Hurlburt, Culver, & Reynolds, 1999; New Freedom Commission on Mental Health, 2003). These populations comprise over one-fourth of the U.S. population, with the largest groups being Latinos (13.5%), African Americans (12.0%), Asian/Pacific Islanders (4.1%), and Native Americans/Alaska Natives (0.7%) (Bernal & Saez-Santiago, 2006). Serious emotional disturbance (SED) prevalence for all children in the United States is estimated to be between 9% to 13%, with only 1% to 2% treated by a mental health specialist (Coard & Holden, 1998; Costello, Burns, Angold, & Leaf, 1993). The gap between need and use is considered to be even greater for culturally and linguistically diverse racial/ethnic groups (Padgett, Patrick, Burns, & Schlesinger, 1994).

Purpose of this Monograph

This monograph presents a description and analysis of the research literature related to child and family mental health among African Americans, Asian Americans/Pacific Islanders, Latinos, and Native Americans. These groups provide a starting point for analyzing the existing literature available to support organizational cultural competence strategies and identify gaps that require further study. Background information for each of these populations is also provided, including population characteristics and community context factors that influence the development, implementation, and operationalization of cultural competence in terms of access, availability, and utilization of mental health services.

A conceptual model is introduced to illustrate potential areas of alignment or discordance between cultural/linguistic population characteristics and organizational components (i.e., infrastructure and direct service domains/functions). By examining relationships and potential points of contact, the model is intended to provide a common framework to facilitate alignment between diverse cultural and linguistic populations and mental health service providers.

A guiding premise of the overall study is that to increase utilization of mental health services by culturally and linguistically diverse children and their families, culturally competent access practices must be present along with a culturally and linguistically adapted and appropriate array of services and supports.

Culture cannot be easily separated from socioeconomic factors and is important to consider in combination with, as well as separate from other factors.

This review is part of a larger study focusing on access to mental health services for culturally and linguistically diverse children and families. Methods used in the overall study include case studies of organizations and systems, systematic collection of input from experts in relevant fields, and an analysis of published cultural competence instruments in addition to the literature review that is the basis of this monograph (Research and Training Center for Children's Mental Health, 2004). A guiding premise of the overall study is that to increase utilization of mental health services by culturally and linguistically diverse children and their families, culturally competent access practices must be present along with a culturally and linguistically adapted and appropriate array of services and supports. The study is therefore focusing on measurable organizational factors associated with increased accessibility and availability of quality mental health services/supports.

Mental Health Disparities

Research concerning the prevalence of mental health problems of racial/ethnic groups shows little difference in rates of specific disorders, but there are differences in referral patterns, problem manifestations, applicability of assessment protocols, and diagnoses (Coard & Holden, 1998; Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, & Landsverk, 2002). While serious emotional disturbance (SED) prevalence for Native American/Alaska Native children is similar to national estimates (9%), suicide rates are 2.5 times higher than the national average (Freeman, Iron Cloud-Two Dogs, Novins, & LeMaster, 2004). Further, the ratio of Native American mental health professionals to children is only 4 to 100,000 while the ratio for Whites is 173 in 100,000 (Center for Mental Health Service [CMHS], 2000; Freeman, Iron Cloud-Two Dogs, Novins, & LeMaster, 2004). African American youths are approximately one-third as likely to receive care as White youths with the same level of need and insurance coverage (Burns, Costello, Erkanli, Tweed, Farmer, & Angold, 1997). Prevalence estimates of depression and underutilization of services among adult Asian/Pacific Islanders are higher than among White populations. It has been suggested that prevalence is most probably underestimated due to unrecognized culture-related factors (Cheung & Snowden, 1990; Herrick & Brown, 1998).

Other researchers report that disparities in the diagnosis and prevalence of mental illness do not appear to correspond to racial/ethnic characteristics, but to social and economic factors that influence access and utilization (Elster, Jarosik, VanGeest, & Fleming, 2003). For example, studies reporting higher depression and suicide for racial/ethnic groups attribute this to refugee/immigration/displacement experiences, discrimination/racism, and stressful economic situations rather than culture/ethnicity (Flisher, Kramer, Grosser, Alegría, Bird, Bourdon, Goodman, Greenwald, Horwitz, Moore, Narrow, & Hoven, 1997; Flores, Fuentes-Afflick, Barbot, Carter-Pokras, Claudio, Lara, McLaurin, Pachter, Gomez, Mendoza, Valdez, Villarruel, Zambrana, Greenberg, & Weitzman, 2002; Freeman et al., 2004; Herrick & Brown, 1998). However, culture cannot be easily separated from socioeconomic factors and is important to consider in combination with, as well as separate from other factors.

Culture and Unmet Need

The importance of considering culture is emphasized by the Surgeon General's report on disparities in mental health care (U.S. Department of Health and Human Services [U.S. DHHS], 2001). The report states that culturally and linguistically diverse children with SED have unmet needs as a result of being inappropriately served or underserved. Unmet need for children and adolescents who experience mental disorders has been reported between 17% and 80%, depending upon the definition of need and the geographic location (Burns et al., 1997; Flisher et al., 1997; Kataoka et al., 2002; Leaf, Alegria, Cohen, Goodman, Horwitz, Hoven, Narrow, Vaden-Kiernan, & Regier, 1996; Sturm, Ringel, & Andreyeva, 2003).

Unmet need has been found to vary by both cultural and socioeconomic factors, but structural factors are implicated as well (Burns et al., 1997; Elster et al., 2003; Flisher et al., 1997; Kataoka et al., 2002; Sturm et al., 2003). Specifically, Latino, African American, and uninsured children and adolescents are experiencing the lowest use and highest unmet need (Burns et al., 1997; Elster et al., 2003; Flisher et al., 1997; Kataoka et al., 2002; Sturm et al., 2003). In addition, some research suggests that African American and Latino youths enter mental health services more often through involuntary means such as child welfare or juvenile justice, pointing to unmet needs in problem identification and early intervention (Alvidrez, 1999; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). The variations in the level of unmet need for racial/ethnic groups across the United States also suggests the strong influence of state and local policies and health care market characteristics in interaction with sociodemographic and cultural characteristics (Flisher et al., 1997; Sturm et al., 2003). These findings point to the need for increased understanding of the complex interplay of social, structural, and cultural factors contributing to disparities in mental health (Alvidrez, 1999; Dressler, 1993; New Freedom Commission on Mental Health, 2003; Yeh et al., 2003).

Importance of Accessibility

According to the President's New Freedom Commission on Mental Health (2003) and the Surgeon General Report on Mental Health (U.S. DHHS, 1999), lack of accessibility to appropriate mental health services and supports for African Americans, Asian/Pacific Islanders, Latinos, and Native Americans is a key issue related to health disparities in these populations. Both reports place an emphasis on understanding and addressing disparities in access to services. Major challenges to increasing access include a lack of systemic and organizational awareness and responsiveness to the community. Awareness and responsiveness include considering the important role culture plays in problem identification, help seeking patterns, referrals, diagnoses, and treatment preferences (Bernal & Saez-Santiago, 2006; Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebniak, & Baydar, 2002; Yeh et al., 2002; Yeh et al., 2003).

Lack of access and availability of services places a greater burden on racially/ethnically diverse populations than White populations (Huang, 2002). This higher burden is due not only to receiving less care (Bui & Takeuchi, 1992; Chabra,

Major challenges to increasing access include a lack of systemic and organizational awareness and responsiveness to the community.

Improving access and availability is key to reducing the additional disability burden for racially/ethnically diverse populations and improving mental health outcomes.

Chavez, Harris, & Shah, 1999; Costello, Farmer, & Angold, 1997; Cunningham & Freiman, 1996; Juszczak, Melinkovich, & Kaplan, 2003; Lasser, Himmelstein, Woolhandler, McCromick, & Bor, 2002; Novins, Beals, Sack, & Manson, 2000; Novins, Duclos, Martin, Jewett, & Manson, 1999; Pumariega, Glover, Holzer, & Nguyen, 1998), but also to poorer quality of care (Walkup, McAlpine, & Olfson, 2000; Wang, West, & Tanielian, 2000; Young, Klap, & Sherbourne, 2001), fewer types and/or amounts of services (Bernal & Saez-Santiago, 2006; U.S. DHHS, 2001), and increased stress for those already challenged by lack of information or resources (Harrison, McKay, & Bannon, 2004; McKay, Pennington, Lynn, & McCadam, 2001).

The disproportionate burden of mental illness on diverse ethnic/racial communities is attributed to a lack of compatibility between services and these communities, rather than a greater severity or prevalence within these populations (U.S. DHHS, 2001). Lack of compatibility between organizations and clients reduces access to appropriate services that can result in misdiagnoses (Fabrega, Ulrich, & Mezzich, 1993; Kilgus, Pumariega, & Cuffe, 1995; Malgady & Constantino, 1998; U.S. DHHS, 2001; Yeh et al., 2002), development of mistrust, and low utilization of services by racially/ethnically diverse populations (Snowden, 1998; Takeuchi, Sue, & Yeh, 1995; Theriot, Segal, & Cowser, 2003; U.S. DHHS, 2001). Improving access and availability is key to reducing the additional disability burden for racially/ethnically diverse populations and improving mental health outcomes.

Defining Cultural Competence

Cultural competence has been named as a guiding principle of systems of care (Stroul & Friedman, 1994) aimed at improving access and availability of services within communities for children with SED and their families. A foundational definition for cultural competence states that it includes behaviors, attitudes, and policies within a system, agency, or among professionals that enable them to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). Underlying this definition is the notion that children's mental health services must acknowledge and incorporate the importance of culture, race, and ethnicity at all levels of functioning and treatment to provide optimal access to quality services for racially/ethnically diverse populations. The recognition that culture, race, and ethnicity have significant influence on the behavior and thinking of providers and service recipients is also an important feature of cultural competence. Therefore, both perspectives need to be understood to increase access to services (Cauce et al., 2002; U.S. DHHS, 2001).

While the concept of cultural competence has gained widespread recognition and provoked changes in thinking about serving diverse communities (Hernandez & Isaacs, 1998; Huang, 2002), much work remains before it can be effectively implemented to reduce mental health disparities (Vega & Lopez, 2001). Cultural competence has remained largely an ideology with a set of guiding principles that lack clear operationalization (Vega & Lopez, 2001). Attempts to operationalize characteristics of culturally competent mental health programs and measure the degree of implementation of cultural competence principles

have fallen short of demonstrating a link between culturally competent practices and improved access, availability, utilization rates, or outcomes of services (Isaacs, 1998; Isaacs & Benjamin, 1991; New Freedom Commission on Mental Health, 2003; Takeuchi et al., 1995).

Linking Cultural Competence to Best Practices Research

Operationalizing cultural competence is an important step toward being able to test its effectiveness in improving mental health service delivery (Sue, 2003). Better operationalization of cultural competence can also contribute to research that identifies and assesses best practices for specific racial/ethnic groups. There is a lack of research identifying best practices with low-income, ethnically/racially diverse communities, especially by key entities such as the National Institute of Mental Health (NIMH) that can help set the agenda for focusing future mental health research (Bernal & Saez-Santiago, 2006). Improved understanding of cultural competence can lead to better inclusion of diverse groups in best practice research through improved data collection and interpretation of data (Nagayama Hall, 2001). For example, culturally competent practices can improve participant recruitment, assist in measuring group differences, and improve the conceptualization of behavior within cultural contexts (Nagayama Hall, 2001). Clear operationalization of cultural competence can also contribute to the identification of effective practices, which can lead to better adaptation of evidence-based treatments for ethnic communities (Bernal & Saez-Santiago, 2006; Isaacs, Huang, Hernandez, & Echo-Hawk, 2005). This type of evidence includes identification of specific organizational strategies that support outreach, engagement, and retention in services of diverse racial/ethnic communities.

The concept of cultural competence needs to be infused into the processes of testing in preparation for efficacy trials with ethnic communities, in addition to recruitment and sampling strategies to ensure that participants approximate the types of cases seen in racial/ethnic communities (Bernal & Saez-Santiago, 2006). Collaboration with diverse communities in all aspects of research will assist in understanding both participants and contexts for such research (Nagayama Hall, 2001). It is anticipated that this type of effort will move the field of mental health toward improved translation and dissemination of culturally competent services and organizational practices in real world settings (Bernal & Saez-Santiago, 2006).

Method

The purpose of this literature review is to (1) assess the status of current mental health research as it relates to racially/ethnically diverse children and families and (2) identify strategies for providing culturally competent mental health services. The literature review stems from a systematic, developmental, and iterative procedure that contributed to ongoing knowledge development for the larger project. The procedures used included electronic searches, coding information into categories, sorting and refining of inclusion criteria, and analysis of themes within domains of access, availability, and utilization of mental health services. Search strategies were developed by the research team in consultation with the

Better operationalization of cultural competence can contribute to research that identifies and assesses best practices for specific racial/ethnic groups.

The initial literature search

identified general search criteria that were applied in six electronic databases covering the key disciplines of education, psychology, social work, medicine, and sociology.

Louis de la Parte Florida Mental Health Institute librarian. The team also developed coding and analysis procedures using EndNote 8, a software tool for managing bibliographies.

Search Procedure

The literature search began by identifying general search criteria and selecting six electronic databases covering the key disciplines of education, psychology, social work, medicine, and sociology. The databases were:

- PsychInfo
- ERIC
- MedLine
- Sociological Abstracts
- Current Contents
- Ethnic News Watch

Broad parameters guided the initial literature search, including:

- Literature from 1994-2004 (10 year search)
- English language only
- Research in the United States only
- Addressing cultural competence of services for racially/ethnically diverse populations
- Focusing on mental health for children/families
- Addressing disparities

Specific search terms were used for each database, starting with individual terms and moving to combination of selected terms in order to narrow the results. Search terms included cultural competence, children, family, mental health, organizations, health disparities, outcomes, barriers, utilization, and service delivery. Related terms discovered in the process of the initial searches were also explored as they were identified.

As a result of the initial search process, over 2,500 articles were identified. Entries from each database were entered into EndNote 8. These entries became the basis for a master library of articles for the literature review. Duplicate articles found in more than one database were deleted. The resulting library included 1,313 articles.

The next step was to examine each entry in detail to determine whether each article matched the inclusion criteria. A total of 127 entries were removed because they were not published in the United States, were published before 1994, or were not based on research or a literature review. A total of 1,186 entries remained in the master library after the inclusion parameters were applied.

Coding Procedure

All entries in the master library were coded for retrieval using EndNote 8 software. Coding was accomplished by examining abstract and other information imported from the databases. Coded information was placed into custom fields created in the database that included:

- Racial/Ethnic Group
- Document Type
- Issues Addressed
- Research Design
- Findings
- Definition of Operationalized Terms
- Implications/Recommendations for Future Research

As a result of the coding process, it was found that some entries made reference to “minority” populations but did not specify the particular racial/ethnic group(s) being studied. These entries were coded as “Non-specific” for racial/ethnic group.

After articles were coded per the inclusion criteria, relevance to the current study was verified by examination of full entries. Two trained researchers coded each article as either yes or no for whether it included a focus on the racial/ethnic populations of interest, had research-based findings, and addressed cultural competence in access, utilization or availability of mental health services for children/families. All entries that received two “yes” responses from the researchers were retained while entries that received two “no” responses were deleted. For example, entries that targeted only adult populations or studied unrelated issues or disorders, such as eating disorders or illicit drug/alcohol use, were deleted. The entries that received one yes response and one no response were reviewed and decided by a third trained researcher. Interrater reliability was 96% for the category of racial/ethnic group, 98% for document type, and 91% for relevance to the monograph. The resulting library included 274 entries that met the inclusion criteria and were found to be relevant to the monograph.

Sorting Procedure

The 274 entries that remained in the master library were sorted into separate libraries for the four major racial/ethnic groupings for full-text review and content analysis. A total of 202 entries were sorted into separate racial/ethnic group libraries while 72 entries that were categorized as Non-specific were put into another library for possible future classification into a specific group. Each racial/ethnic group library was then sorted based on Document Type. The categories that emerged for this sorting included:

1. *Research Articles* (presenting the results of research of racial and ethnic diversity in child and family mental healthcare)
2. *Context Articles* (providing broader background and/or contextual information)

Coding was accomplished by examining abstract and other information imported from the databases. Coded information was placed into custom fields created in the database.

Common themes identified during the article reviews included: Barriers, Ethnic Match, Outreach, Dropout Rates, Stigma, Length of Treatment, Service Delivery, Unmet Needs, and Role of the Family.

3. *Other Articles* (representing opinions and/or conceptual representations of issues relating to racial and ethnic diversity, or non-relevant information)

Articles that were classified as Research or Context were used to develop the findings of this monograph. The other articles were coded as either Conceptual or Non-relevant articles and placed in a separate library. In the process of sorting, it was found that the content of many articles targeted more than one racial/ethnic population. Therefore, these entries were placed into the racial/ethnic group libraries for which they applied. When articles mentioned a combination of racial/ethnic groups, those articles were included in all appropriate racial/ethnic libraries.

Identification of Themes

Coded EndNote 8 libraries were analyzed for themes in the categories of Access, Availability, Utilization, and Outcomes of services for each racial/ethnic group. Identification of themes used an iterative process that included (a) examination of the EndNote 8 custom field of “Issues,” (b) examination of full articles for additional information about issues, (c) categorization of all issues into an outline of potential categories, (d) creation of a list of categories and sub-categories, and (e) creation of a list that matched relevant articles with each category and sub-category. The first three steps were conducted by an individual researcher working on one racial/ethnic group library. After an outline of potential categories was created for a racial/ethnic group, it was presented to the full research team for discussion. Based on a consensus reached during the discussion, categories were modified or expanded. After the discussion and adjustment of all racial/ethnic groups, an overall outline of issue categories was created that included themes common to all racial/ethnic groups.

In-depth reviews were also conducted with the *Research* and *Context* articles by reading full articles for content related to the objectives of the monograph. Common themes identified from the article reviews and EndNote8 analysis included Barriers, Ethnic Match, Outreach, Dropout Rates, Stigma, Length of Treatment, Service Delivery, Unmet Needs, and Role of the Family. These themes became the basis for the construction of a conceptual model for organizational cultural competence and the organization of this monograph. Themes that differed for each racial/ethnic group were included in relevant chapters of this monograph.

Next, *Research* articles and EndNote 8 libraries for each racial/ethnic group were reviewed for themes related to method and findings. Each of the four EndNote 8 racial/ethnic libraries was analyzed for common and unique themes in the following EndNote 8 coded entries: Racial/ Ethnic Group; Research Design; Findings; Definitions of Operationalized Terms; and Implications/ Recommendations for Future Research. Articles were reviewed to provide more specific information about study design, sample selection, and key findings. Results were then summarized and incorporated into tables and narratives included in each racial/ethnic group chapter of this monograph.

In the process of the in-depth review, additional *Research* articles were identified and incorporated into the monograph. These articles were examined for relevance and match with the inclusion criteria and entered into the appropriate

EndNote 8 libraries. The final count for *Research* articles included in this literature review was 57. Of these articles 32 studied African Americans, 14 studied Asian/Pacific Islanders, 27 studied Latinos, and 10 studied Native Americans. Some articles included more than one ethnic group in their study sample, as shown in Figure 1.

Background Material

An extensive collection of background materials was compiled to develop the proposal for this research project and was also available for this monograph. A majority of background materials was in the form of articles or book chapters, but also included conference presentations, program reports, and annual reports. Many of the latter did not fit the criteria for the literature review because they were published before 1994, focused on adults rather than children, addressed health rather than mental health, or were not research articles. Some of the materials that were not included in the formal literature review were used for background information or to inform the study design and approach.

Articles found in the literature review that were classified as Conceptual articles were also used as references for the introductory sections and descriptions of specific populations. A total of 169 articles in this category were entered into EndNote 8 and subsequently divided into racial/ethnic groups and reviewed for background information. These documents were not included in the findings of the literature review or the final count of research articles.

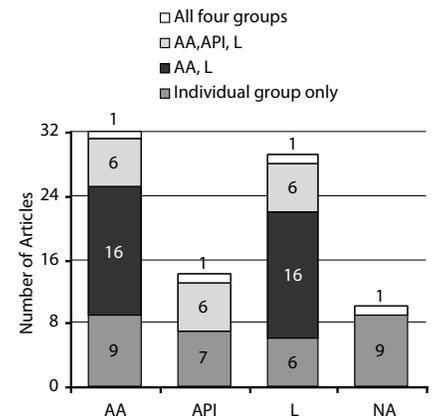
Conceptual Model for Organizational Cultural Competence

A definition of organizational cultural competence and an accompanying conceptual model (Hernandez & Nesman, 2006) were developed based on the thematic analysis conducted for this literature review. An examination of cultural competence definitions, strategies to increase access for diverse populations, and existing cultural competence assessments also contributed to the development of this conceptual model. Key elements found in cultural competence definitions included:

- Specific types of behaviors, knowledge, attitudes, policies, and procedures (e.g., acceptance, respect, regard, flexibility)
- Working effectively and efficiently when faced with cultural differences and populations of color
- Congruence across system components/levels
- Engagement in self-assessment
- On-going development of knowledge, resources, and service models (Center for Mental Health Services [CMHS], 1997; Cross et al., 1989; Siegel, Davis-Chambers, Haugland, Bank, Aponte, & McCombs, 2000).

A further understanding of the relationship between organizational structures and processes and direct service functions was developed through an examination of items in cultural competence assessment protocols and conceptual information identified through this literature review. Based on these sources the

Figure 1
Frequency of Research Articles
by Racial/Ethnic Group



following definition of organizational cultural competence was developed:

Within a framework of addressing mental health disparities, the level of a human service organization's/system's cultural competence can be described as the degree of compatibility and adaptability between the cultural/linguistic characteristics of a community's population AND the way the organization's combined policies and structures/processes work together to impede and/or facilitate access, availability, and utilization of needed services/supports.

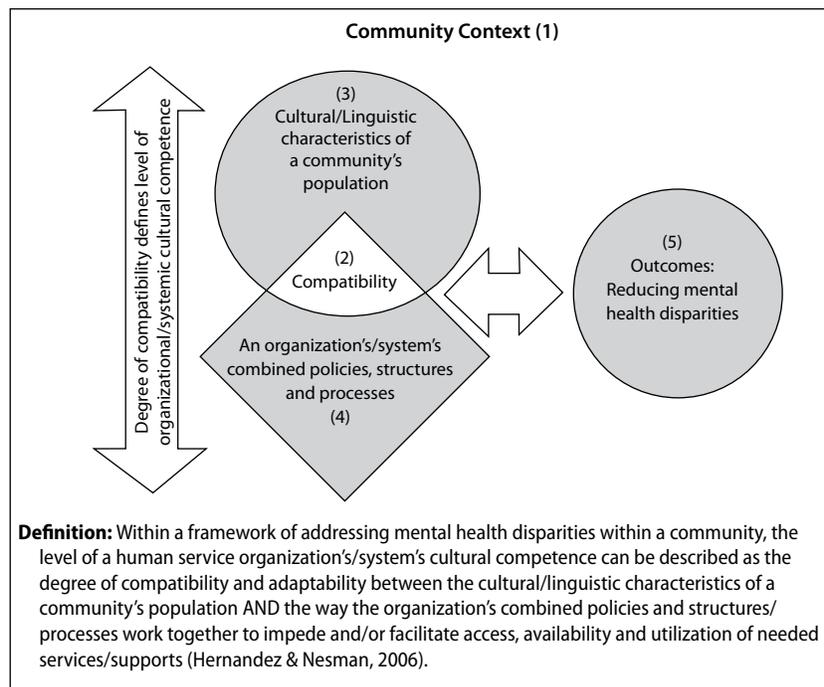
The **compatibility** between the organization's/system's structures and processes and the community's populations determines the level of cultural competence.

Description of Conceptual Model

The conceptual model (Hernandez & Nesman, 2006) operationalizes the definition of organizational cultural competence further by illustrating the relationships between the community's populations, organizational structures and processes, direct service structures and processes, and the overall community context (Figure 2).

As Figure 2 indicates, the compatibility between the organization's/system's structures and processes and the community's populations determines the level of cultural competence. The expected ultimate outcome of organizational cultural competence is reduced mental health disparities for children and their families in the community.

Figure 2
Conceptual Model of Organizational Cultural Competence:
Conceptual Model for Accessibility of Mental Health Services
to Culturally/Linguistically Diverse Populations



1. Community Context

The conceptual model (Hernandez & Nesman, 2006) illustrates the importance of understanding the community context in the development of compatibility between organizations and populations served. This concept is based on the recognition that children/adolescents and their families respond to mental health problems and concerns within a context of the larger social environment that guides or pushes them toward or away from various types of services (Cauce et al., 2002). It also recognizes that organizations and systems function within larger community, state, and national contexts that impact their attempts to serve their local community.

The influence of contextual factors is seen by the different pathways through which racially/ethnically diverse individuals enter into care. For example, contextual factors are related to greater proportions of African American adolescents entering mental health care through involuntary commitment (such as juvenile justice) compared to Whites with the same levels of symptomatology (Cauce et al., 2002; Fabrega et al., 1993; McCabe et al., 1999; Takeuchi, Bui, & Kim, 1993; Yeh et al., 2002). Influences of contextual factors are also seen in a greater proportion of Native American adolescents who are untreated or removed from their homes (Cauce et al., 2002). Such differences in pathways to care are considered to be influenced not only by family choices or cultural difference, but also through a dynamic interaction between contextual and systemic factors such as availability of services and supports within the community or social networks that provide referrals to services (Cauce et al., 2002). Understanding the process of help seeking that occurs prior to entering the formal mental health system is an important part of organizational cultural competence.

2. Compatibility of Organizational Structures and Processes

The model of organizational cultural competence (Hernandez & Nesman, 2006) emphasizes the need to adapt the organization's policies, structures and processes to the characteristics of the community being served in order to reduce disparities. The degree of compatibility defines the level of cultural competence in the organization. Compatibility between the community's populations and organizational policies, structures and processes could be determined by the level of access to and utilization of appropriate services by racially/ethnically diverse populations in the community.

3. Knowledge of the Population

Assessing compatibility and therefore cultural competence is dependent upon having information about the community's populations, context, and the organization's policies, structures, and processes. Knowing the community's populations includes awareness of the influences of culture, ethnicity, race, socioeconomic status, and related social factors on the provision of services and help-seeking. As pointed out by Staudt (2003), it is important to link interventions to the factors that contribute to a lack of engagement by children and families and to recognize that these factors will vary across groups and service types. Development of compatible strategies will not be possible without this information.

Organizations and systems

function within larger community, state, and national contexts that impact their attempts to serve their local community.

Knowing the community's

populations includes awareness of the influences of culture, ethnicity, race, socioeconomic status, and related social factors on the provision of services and help-seeking.

It is important to look for variability within a culture rather than considering it to be consistent across all potential members.

Understanding culture includes identifying shared social norms, beliefs, and values, as well as spoken languages, and how institutions such as marriage, family, or education are viewed and practiced (Guerra & Jagers, 1998). It is also important to look for variability within a culture rather than considering it to be consistent across all potential members. Consideration should be given to how culture develops in response to specific contextual demands (Cauce et al., 2002) and the changes that may occur as the context changes (Bernal & Saez-Santiago, 2006). This dynamic view of culture provides a way to understand populations where families and individuals maintain widely varying beliefs or attitudes about specific aspects of the culture (Dressler, 2006). Although it is certain that culture impacts how families and providers think about seeking/providing help, defining/diagnosing problems, or understanding/treating mental health conditions, the way that culture impacts these perspectives may vary. Therefore, the way culture is being defined should be carefully considered (Akutsu, Snowden, & Organista, 1996; Alvidrez, 1999; Cauce et al., 2002).

Understanding the role of race in service access and utilization is also important to developing compatible service systems. Although biological foundations or genetic roots for commonly accepted racial categories have been discounted (Bonham, Warshauer-Baker, & Collins, 2005; Williams, 1997), it is important to consider race as a component of social identity (Cauce et al., 2002) and as a contributor to decision-making processes that result in disparities (Balsa & McGuire, 2003). For example, health disparities have been linked to decreased willingness of doctors to interact with racially and ethnically diverse clients, different interpretations of symptoms, and stereotypes about health related behaviors (Balsa & McGuire, 2003; Institute of Medicine, 2002). Better understanding of underlying causes of disparities linked to race can point to important organizational adaptations, such as whether to focus on information-based policies (e.g., provider and patient education) or rule-based policies (e.g., requirements aimed at equity) (Balsa & McGuire, 2003).

Ethnicity is important to consider as a way that specific groups within a multicultural society indicate membership through cultural, linguistic, attitudinal, or physical markers or characteristics. It is also a component of a sense of self, influencing hopes, values, and goals, and how people think others view them (Gamst, Dana, Der-Karabetian, Aragon, Arellano, & Kramer, 2002; Phinney, 2000). In the mental health care arena, ethnicity has been associated with help-seeking strategies and pathways into care, as well as patterns of utilization of mental health services (Cauce et al., 2002; Chow et al., 2003). The concept of ethnicity is often used in place of race because it de-emphasizes biological or genetic roots and allows for a consideration of greater variability (Dressler, 1993).

Level of acculturation, migration history, and displacement experiences are also important for understanding how to serve diverse populations. Acculturation, or the adaptation to a host culture, may result in varying relationships for both the host and immigrant/displaced cultures. Types of relationships have been described as assimilation, integration/biculturalism, separation/traditionalism, and marginalization/peripheral status (Gamst et al., 2002).

Acculturation status has been linked to mental health, but the process is unclear. For example, there is some evidence that individuals at the midpoint of acculturation experience better mental health than those at either extreme of the continuum (Rogler, Cortes, & Malgady, 1991). Less acculturated individuals may experience poorer mental health due to stress and lack of social networks, while more acculturated individuals experience poorer mental health due to stress of racism and stereotyping (Rogler et al., 1991). Although further research is needed to better describe the relationship between acculturation and mental health, it is clear that organizational cultural competence can be enhanced by taking into consideration the range of acculturation levels within populations served.

Socioeconomic status is another important feature of access, but is not clearly distinguishable from culture/race/ethnicity (Cauce et al., 2002). In the United States, the overlap between SES and culture/race/ethnicity can be significant, especially when considering how racial/ethnic groups adapt to challenging socioeconomic situations. Socioeconomic status has been specifically tied to barriers such as lack of insurance, time, and transportation that impact utilization of mental health services (Alvidrez, 1999). However, as Dressler (1993) points out, society-wide processes such as social closure, or assignment of social status based on visible characteristics like skin color, suggest a more deep-rooted relationship between race/ethnicity and social position that impacts access to services. There is a need for better understanding of the variables contributing to social position, including race/ethnicity, poverty status, culture, education, and others (Alegría, Canino, Rios, Vera, Calderón, Rusch, & Ortega, 2002), and for improvement of theoretical frameworks that guide research related to disparities (Dressler, 1993). A more comprehensive theory of socioeconomic status that incorporates concepts of race/ethnicity will facilitate the process of developing appropriate policies and strategies for increasing access for diverse populations.

4. Domains of Organizational Structures and Processes

Two types of organizational structures and processes are important to consider in organizational cultural competence as depicted in Figure 3 (Hernandez & Nesman, 2006). The Infrastructure component includes organizational functions, while the Direct Service component includes functions related to Access, Utilization, and Availability of services. A culturally competent organization seeks compatibility between and within infrastructure and direct service domains.

Components of the Infrastructure and Direct Service domains are illustrated in more detail in Figure 4 (Hernandez & Nesman, 2006). As shown, compatibility is needed between these domains as well as with the community.

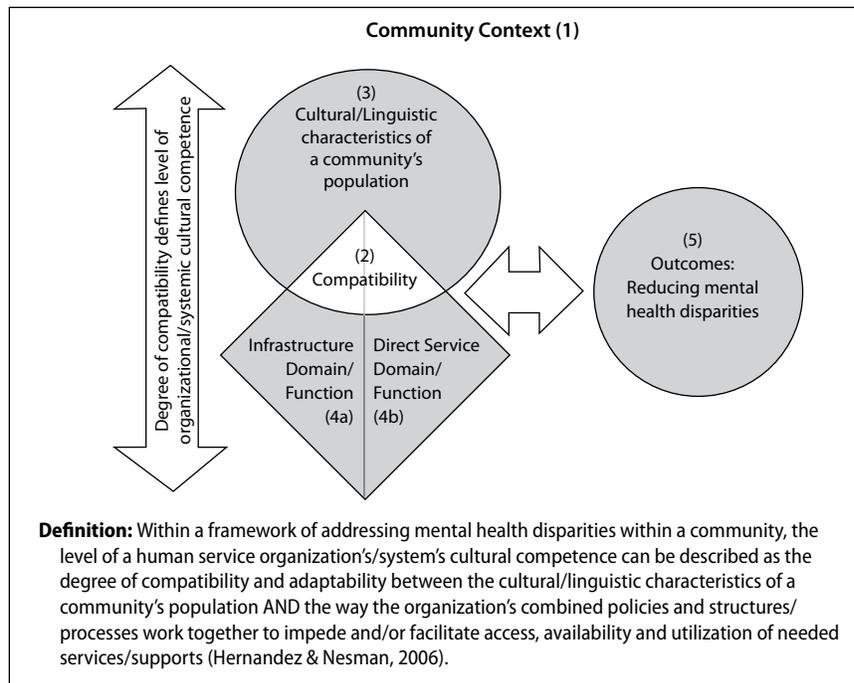
4a. Infrastructure

The Infrastructure domain is made up of multiple functions that are typical of organizations, each of which must be adapted for cultural competence. Organizational values, policies, procedures and governance contribute to cultural competence when they promote compatibility with the community served and provide support for staff to carry out needed culturally competent service practices. Likewise, planning and evaluation processes contribute to cultural compe-

Organizational cultural competence can be enhanced by taking into consideration the range of acculturation levels within target populations.

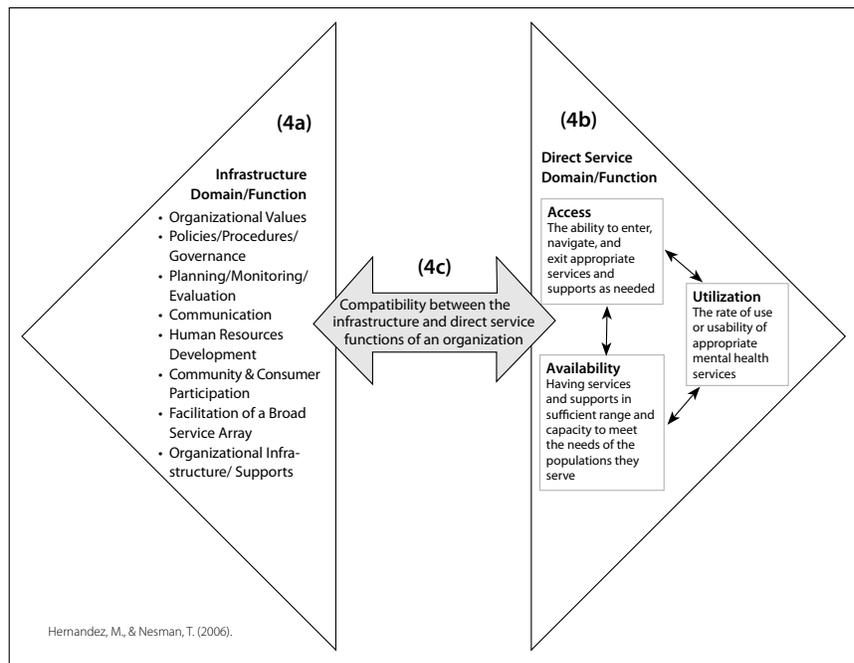
A culturally competent organization seeks compatibility between and within infrastructure and direct service domains.

Figure 3
Conceptual Model of Organizational Cultural Competence:
Compatibility Between the Community and Organizational Domains



Planning and evaluation processes contribute to cultural competence when they include communities of color as fully contributing partners with shared responsibilities, and when they collect data that reflects the diversity of the community.

Figure 4
Conceptual Model of Organizational Cultural Competence:
Organizational Infrastructure and Direct Service Domains



tence when they include communities of color as fully contributing partners with shared responsibilities, and when they collect data that reflects the diversity of the community. Communication that supports cultural competence includes two-way communication and learning within the organization and between the organization and the community. Human resources and service array domains include strategies to increase bilingual/bicultural capacity, recruitment, and retention, and availability of services that are appropriate and of high quality for the target population. Methods of outreach to communities and opportunities for community/consumer participation are important mechanisms that can lead to greater compatibility. Organizational infrastructure can promote cultural competence by bringing in financial, technological and other needed resources.

4b. Direct Service

The Direct Service domain of an organization includes functions related to access, utilization, and service availability. Access is defined as mechanisms that facilitate entering, navigating, and exiting appropriate services and supports as needed. Availability is defined as having services and supports in sufficient range and capacity to meet the needs of the populations they serve. This may include availability of bilingual personnel and/or trained translators. Utilization is defined as the rate of use of services or their usability for populations served. Utilization may include issues such as length of time in service, retention, or dropout rates.

4c. Compatibility between the Organizational Infrastructure and the Direct Service

The conceptual model of organizational cultural competence (Hernandez & Nesman, 2006) shows that compatibility is needed between each of the Direct Service functions and the community, as well as with the Infrastructure functions in order to appropriately serve the target population and produce desired outcomes. A similar model proposed by Bernal and Sáez-Santiago (2006) emphasizes the need for “cultural congruence” between client and therapist but is aimed solely at the treatment level. Dimensions of cultural congruence described in this model include language use, relationship between client and provider, use of metaphors (concepts and symbols) in therapy, cultural knowledge about the client, problem and treatment conceptualization, development of goals/methods/procedures for treatment, and awareness of the client’s broader social/economic/political context (Bernal & Sáez-Santiago, 2006). Although focused on the treatment level, this model portrays the importance of compatibility of services with the population served. The importance of compatibility is also supported by studies of “culturally responsive services,” which are linked to decreased barriers, improved retention in services, and increased positive client outcomes for populations of color (Diaz, Prigerson, Desai, & Rosenheck, 2001; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Additionally, the availability of culturally/linguistically appropriate services has been associated with outcomes such as increased use of and satisfaction with services among ethnic clients (Akutsu et al., 1996).

The conceptual model presented in this monograph also shows that there is a need for compatibility between the organizational infrastructure and direct service, as well as between each of the direct service domains (Hernandez &

Access: mechanisms that facilitate entering, navigating, and exiting appropriate services and supports as needed

Availability: having services and supports in sufficient range and capacity to meet the needs of the populations they serve

Utilization: the rate of the use of services or their usability for populations served

Compatibility is needed

between each of the Direct Service functions and the community, as well as with the Infrastructure functions in order to appropriately serve the target population and produce desired outcomes.

Nesman, 2006). Dynamic relationships are shown by two-way arrows between infrastructure supports, access mechanisms, and availability of needed/appropriate services. An example of this relationship might be as follows: Access is increased through a one-stop family services center, but there is a lack of availability of bilingual services and lack of trust in the organization because it is not connected with the community. This lack of trust or bilingual capacity results in low levels of utilization of services and little improvement in outcomes. The dynamic relationship between these components is especially important to recognize as organizations make changes. Changes in one area may affect other areas, or lack of change in one area may cancel out efforts in other areas. Incorporating cultural competence into every aspect of the organization or system requires careful consideration of compatibility of policies and strategies with the population served as well as with the other organizational functions.

5. Outcomes

The ultimate outcome of a culturally competent organization is reduced mental health disparities, as shown in Figure 3. Outcomes should be measured at multiple levels in order to determine the impact on reducing disparities. For example, outcomes at the organizational level might include increased access, decreased dropout, and decreased no show rates for formerly underserved populations. Outcomes might also be seen at the population level, such as increased use of outpatient services or decreased use of crisis and inpatient services. Some studies have begun to show a link between culturally competent practices and outcomes such as decreased barriers, improved retention in services, and increased positive client outcomes (Diaz et al., 2001; Sue et al., 1991). The availability of culturally/linguistically appropriate services has also been associated with increased use of and satisfaction with services among clients of color (Akutsu et al., 1996). It has been suggested that individual and family outcomes such as improved clinical outcomes, improved social functioning, and empowerment can indicate organizational cultural competence, but these should be considered along with outcomes at other levels to determine the impact on reducing disparities (Siegel, et al., 2000; Snell-Johns, Mendez, & Smith, 2004).

How Each Chapter is Organized

The following four chapters each focus on one population and describe findings from the literature review related to characteristics of the population and direct services that relate to cultural competence. Consistency was sought in referring to each racial/ethnic group by using the following terms: African American, Asian/Pacific Islander, Latino, Native American, and White. However, in cases where authors used a different name for a group, that name was used for describing their particular findings. For example, some authors used the terms Caucasian, non-Hispanic White, Black, Hispanic, American Indian, and/or Alaska Native.

The findings are organized according to the conceptual model for organizational cultural competence. The chapters begin with characteristics of the population and the community context that affects access to and availability of appropri-

ate services. Next, the findings from research articles are described, including such categories as barriers to access, strategies for increasing access, types of services that are available, gaps in services, utilization rates, and levels of unmet need.

The final chapter of the monograph provides broad conclusions about the status of the literature on organizational cultural competence in children's mental health, and summarizes findings that are common across populations. Recommendations for practice and research are provided for each racial/ethnic group in individual chapters and are summarized in the final chapter.

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2

Research with African American Populations

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Poverty levels for African Americans continue to be among the highest in the country and especially impact children.

African American Populations

The previous chapter introduced the concept of cultural competence, its definition, and a model for its application in addressing mental health disparities among culturally and linguistically diverse children and families. The conceptual model illustrating the degree of compatibility between general population characteristics identified for African American populations and organizational components of mental health service providers will be applied within this chapter to provide a link between program planning and service delivery.

Background

The African American population totaled 35.5 million (nearly 12.3% of the national population) in 2000; an additional 1.8 million people self-identified as a combination of Black/African American and one or more other races (McKinnon, 2001). Census data also show a 16% (5 million) increase in the number of African Americans from 1990 to 2000, compared to an 11% increase for the White population (U.S. Department of Health and Human Services [U.S. DHHS], 2000). Current projections indicate that the African American population could grow to 64.14 million by the year 2050 (U.S. Census Bureau, 2004).

The U.S. Census reports the median household income for African American households in 1999 was almost \$28,000, the highest recorded until this time. Among married African American families, 52% had a household income of \$50,000 or more and 27% had a household income of \$75,000 or more (U.S. Census Bureau, 2000). Despite considerable economic gains, poverty levels for African Americans continue to be among the highest in the country and especially impact children. Nearly 8.1 million African Americans live below the poverty level. The poverty level for the total U.S. population was approximately 12% in 2000, but was recorded at nearly 23% for African Americans. Furthermore, the poverty rate reported for African American children under age 18 was 30%, compared to a much lower 10% for White children and adolescents (U.S. Census Bureau, 2000).

African American families are generally larger than White families. According to a press release by the U.S. Department of Commerce, 2000 Census data estimate that 21% of married African American families had five or more members, compared to 12% of White married families (U.S. Census Bureau, 2001a). The 2000 Census data also reveal that the African American population in the United States is considerably younger than the White population. The median age for the African American population is 30.4 years compared to a median age of 37 years for the White population and 35.3 years for the U.S. population as a whole.

Changes to reporting

of social and ethnic data for Census 2000 make comparisons with previous data more difficult, especially with regard to interpretation of changes in the country's racial composition.

Additionally in 2000, just 19.5% of the White population was under the age of 15, compared to 27.2% of the African American population (U.S. Census Bureau, 2001a).

The U.S. Census Bureau defines the category “Black or African American” as including individuals “having origins in any of the Black race groups of Africa” (McKinnon, 2001, p.1). Because it is a racial category, it includes individuals who identified themselves for the Census 2000 as “Black, African American, or Negro or wrote in entries such as Afro American, Nigerian, or Haitian” (McKinnon & Bennett, 2005). Changes to reporting of racial and ethnic data for Census 2000 were issued by the Federal Office of Management and Budget (OMB). The most significant change granted respondents the option to select more than one race category to indicate racial identity. While such changes allow for more precise self-reporting and ostensibly, update the Census with regard to “new technologies... changing lifestyles and emerging sensitivities” (Grieco & Cassidy, 2001, p. 1), they make comparisons with previous data more difficult, especially with regard to interpretation of changes in the country's racial composition. The use of racial categories in public health and other research has been vigorously debated among researchers for a number of reasons, especially with regard to the issue of reducing health disparities (Bagley, 1995; Fullilove, 1998; Lee, Mountain, & Koenig, 2001; Williams & Jackson, 2000). Williams and Jackson (2000) argue that current Census reporting on race does not accurately reflect the linguistic and ethnic diversity of the Black population in this country, despite the OMB changes. The growing numbers of Sub-Saharan Africans, Haitians, and English-speaking Black West Indians in this country accounted for 4% of the total Black population in the 2000 Census (Grieco & Cassidy, 2001). Moreover, as Williams and Jackson (2000) note,

An African American born and raised in the South, a Jamaican, a Haitian, a Kenyan, and an African American born and raised in the Northeast are all Black, but they are likely to differ in terms of beliefs, behavior, and perhaps even physical functioning (p. 1729).

Historical and Contemporary Racism

African Americans occupy a unique place in the social history of this country because of a long collective experience with forced migration from Africa, enslavement, and institutionalized violence and oppression that lasted into the 20th Century. Although the first Africans to arrive with Europeans in North America came as indentured servants who were able to fulfill work obligations and secure their freedom (Berlin, 2003; Boulin Johnson & Staples, 2005; Higginbotham, 1978), the rise of large-scale agricultural industries based mainly on tobacco, sugar, and cotton led to the development of a severe form of slavery based on racial ideology (Graves, 2001; Oliver & Muntaner, 2005; Smedley, 1999). The rise of the Atlantic Slave Trade resulted in the forcible displacement of an estimated 13 million Africans of diverse languages and ethnicities, originating from various parts of the continent including West Africa, Central Africa and the southeast portion of the continent (Salas, Richards, Lareu, Scozzari, Copa, Torroni, Macaulay, & Carracedo, 2004). Nearly 2 million captured Africans are thought to have died during the treacherous Middle Passage between Africa

and their ultimate destinations in the Western Hemisphere (Salas et al., 2004). Africans who survived the journey often encountered brutal conditions and were stripped of political status, their autonomy, and even, control over their physical bodies (Boulin Johnson & Staples, 2005; Franklin & Moss, 2000). The ratification of Amendments 13, 14, and 15 to the U.S. Constitution abolishing slavery and conferring citizenship and the right to vote to former slaves, did little to fulfill their promise following the election of President Rutherford B. Hayes in 1877 and the withdrawal of federal troops enforcing the new federal laws from Southern states (Vazzano, 2006). The end of Reconstruction heralded the age of Jim Crow in the South, during which Southern states enacted laws that sanctioned strict segregation of Blacks, repealed voting rights, and continued legally enforced discrimination into the 1960s (Dailey, Gilmore, & Simon, 2000). Although officially imposed, the laws of the Jim Crow South were also enforced through mob violence, in which average citizens participated actively or as spectators (Dailey et al., 2000). Although laws in Northern states did not officially sanction segregation, inequalities persisted in housing, employment, legal treatment, and education (Douglas, 2005; Steinberg, 2000).

Traditionally, historians such as Elkins (1976) and Frazier (1966) argued that the horrors of American slavery and its aftermath shaped the development of African American families, helping to explain the negative social conditions of present generations. Such scholarship was used by policymakers to justify negative depictions of African Americans, characterized by highly unstable and disorganized families, ironically in the development of social programs to fight poverty (Gaines, 2005; Johnson & Staples, 2005; Moynihan, 1965). Responding to these official characterizations of African Americans a number of historians and historical demographers published studies debunking such popular myths and highlighting the importance and persistence of Black family connections during slavery and after (Blassingame, 1979; Franklin & Moss, 2000; Genovese, 1976; Gutman, 1977; Stack, 1974). More recent scholarship focused on the resilience of African American families and their extended social networks, stressing “the developmental and ever-changing structure of Black family” in response to often-difficult historical conditions (Giordano, Cernkovich, & DeMaris, 1993; Johnson & Staples, 2005; Taylor, 1986).

Social psychologist John Dovidio has studied a form of modern racism developing at a latent and often unconscious level within individuals. Dovidio’s theory of modern racism stems from the idea that society’s external value in racial equality may actually conceal an internal propensity towards racist values or tendencies. In a country that has worked to publicly project a melting pot image of diversity and acceptance, there is a tendency to misjudge the extent to which racial disparities persist (Dovidio, Gaertner, Kawakami, & Hodson, 2002). Studies testing implicit and explicit responses to images of Black and White faces interspersed with positive and negative imagery or words show that racism and bias is subtle and often unconscious (Dovidio, Kawakami, Johnson, Johnson, & Howard, 1997; Greenwald, McGhee, & Schwartz, 1998). However subtle or unconscious such reactions may be, individual perceptions shape the ways in which individuals interact with others and thus, impact the larger social landscape (Dovidio et al., 2002).

More recent scholarship

focuses on the resiliency of African American families and their extended social networks, stressing their capacity to adapt and respond to often difficult social and historical conditions.

Disorders such as drug or alcohol addiction are not more prevalent among African American populations (Sue & Chu, 2003).

Discrimination and racism can affect mental health needs, the quality of services received, diagnoses, and the rates of services used (Dana, 2002; Flaskerud & Hu, 1992; Nagayama Hall, 2001; Snowden, 2001; Snowden, 2003; Snowden & Cheung, 1990; Sue & Chu, 2003; Williams, Neighbors, & Jackson, 2003; Worthington, 1992), and should be considered in all program planning and research efforts if disparities are to be reduced. Service providers must acknowledge experiences of racism and discrimination within health and mental health systems, and such incidents require targeted attention in organizations (Thompson & Neville, 1999). Further, providers may perceive African Americans as being overly sensitive or easily upset and as having personal issues or problems rather than recognize legitimate responses to discrimination (Nagayama Hall, 2001). The acceptance of misperceptions of this type on the part of providers can elide the possibility that client problems may be inextricably linked to the structural inequities in government, social institutions, and other organizations that have developed over the course of U.S. history (Thompson & Neville, 1999). Such misperceptions may also obscure the need to address necessary changes in an organization's infrastructure and service delivery functions that can improve the quality of care for African American clients.

Mental Health and Prevalence Rates

Many studies have documented prevalence rates of mental health disorders in the United States that can be discussed in relation to African Americans. When considering existing disparities in access, availability, and use of formal mental health services for African Americans, it is helpful to examine national studies that have tracked trends in mental disorder rates. However, several researchers have been quick to note that while these surveys present the best information currently available, the findings present inconsistent or incomplete descriptions of the mental health characteristics of African American populations (Snowden, 2001; Sue & Chu, 2003).

The Epidemiological Catchment Area Study (ECA) represented the first attempt to gather national data on the frequency and distribution of mental health disorders. The final sample included 4,638 African Americans out of more than 19,000 total participants. The findings of the ECA challenged the conventional wisdom shaping popular and scientific opinion regarding disease and mental illness. For example, ECA findings suggest that disorders such as drug or alcohol addiction are not, as were previously thought, more prevalent among African American populations (Sue & Chu, 2003). Furthermore, ECA findings indicate that African Americans are less likely to be depressed than White populations (Sue & Chu, 2003; Zhang & Snowden, 1999).

The National Comorbidity Survey (NCS), conducted in the early 1990's, contained 666 African Americans out of an overall sample of 5,877. Findings from the NCS suggested that African Americans have lower rates of mental illness than White populations (Kessler, Berglund, Zhao, Leaf, Kouzis, Bruce, Freidman, Grosser, Kennedy, Narrow, Kuehnel, Laska, Manderscheid, Rosenheck, Santoni, & Schneier, 1996; Snowden, 2001; Sue & Chu, 2003). Sue and Chu (2003) noted that lower rates of mental illness were surprising because African American popula-

tions often experienced higher levels of stress due to experiences of discrimination, racism, and higher rates of representation in population groups that were at higher risk (e.g., lower socioeconomic status).

A third study, The National Survey of American Life (NSAL), sponsored by the National Institute of Mental Health (NIMH) (2006), is considered the most thorough study of African American populations. The total sample size was 7,000, including 4,000 African Americans, 1,500 Black Americans of Caribbean descent, and 1,500 non-Hispanic Whites. Findings from the NSAL suggested that African Americans had lower rates of depression, panic disorders, social phobia, agoraphobia, generalized anxiety disorder, and dysthymia compared to Whites (Sue & Chu, 2003). While NSAL findings suggest that the African American population might have lower rates of mental disorder than Whites, inconsistencies remain in rates of access, availability, and utilization of health and mental health services among African Americans.

Findings

Overview of Articles Reviewed

The articles that contributed to the findings of this chapter are summarized in Table 1. Of the 31 research articles, 19 were published between 2000 and 2004 and 12 were published between 1994 and 1999. The largest number of articles was published in the years 2001 and 2002, with five articles each.

Among the ten articles that addressed African American populations exclusively (or compared only African Americans with Whites), three articles were related to spirituality. These articles approached the topic of spirituality from different perspectives, including: 1) the role of African American churches in the South, 2) the ways in which spirituality affects mental health and recovery for women and their children, and 3) an examination of a spiritually/culturally based program serving children in need. Of the remaining seven articles focusing on African American populations, one compared self-esteem for children and adolescents, and the remaining six articles examined issues related to utilization.

Among the articles addressing issues of availability, many focused on ethnic and racial matching for adult populations, but only three were related to children. Findings from these three studies focusing on children are difficult to generalize, as all three studies took place in California. Of the 31 research articles, 23 examined children, adolescents, or families and 8 examined populations of all ages, but included children or adolescents in the datasets.

Many of the articles that covered issues related to access also linked findings to availability and utilization of services. The most commonly covered issues related to access include barriers, help-seeking, unmet need, and bias.

While research findings suggest that the African American population might have lower rates of mental disorder than Whites, inconsistencies remain in rates of access, availability, and utilization of health and mental health services among African Americans.

Table 1
Summary of Literature Review Articles: African American

Citation	Sample			Issues Addressed	Direct Service Domain
	Participants	Location	Age		
Alegría et al. (2002)	N =8,098 (987 AA, 695 L, 6,026 W) English Speaking Only	United States	15-54	SES; Service Types; Socio-Geographic Location	Availability Utilization
Blank et al. (2002)	N=269 Churches (181 AA, 88 W)	Urban & Rural South: AL, AR, FL, GA, KY, LA, MD, MS, NC, SC, TN, VA	Child & Adult Church Members	Spirituality/Church	Availability
Brome et al. (2000)	N =146, AA Only	Roxbury, MA	6-14; Women with Children	Spirituality/Church	Availability
Chow et al. (2003)	N =78,085 AA 23,683, API 1,275, L 19,849, W 33,278	NYC, NY; Urban	All Ages	Socio-Geographic Location	Utilization
Cuffe et al. (2001)	Cycle 1: 579 (137 AA, 442 W); Cycle 2: 490 (108 AA, 382 W); Cycle 3: 330 (59 AA, 271 W)	SE U.S. Suburban School District	Middle & High School	Socio-Geographic Location	Utilization
Cuffe et al. (1995)	N= 478; (17% AA, 83% W)	SE U.S. Suburban School District	Middle & High School	Bias; Treatment Length	Access Utilization
Diala et al. (2000)	N=6,167 (743 AA, 4,920 W)	48 Contiguous U.S. States	15 – 54	Attitudes about Help Seeking	Access Utilization
Diala et al. (2001)	N =8,098 (AA,W)	48 Contiguous U.S. States	15 – 54	Attitudes about Help Seeking	Access Utilization
Flisher et al. (1997)	N =1,285 Pairs (190 AA, 361 L, 71 O, 663 W)	CT, GA, NY, & Puerto Rico	Children & Parent Pairs	Correlates of Unmet Need; Personal & Familial Perceptions	Access
Gamst et al. (2004)	N =1,946 (426 AA, 851L, 669 W)	Eastern LA County, CA; Public, Outpatient MHS	6-18	Ethnic Match; Treatment Outcomes	Availability
Gray-Little et al. (2000)	N=261 Comparisons (AA, W)	N/A	Studies with Children, Adolescents, & College Age	Self-Esteem	Characteristics of the Population
Gregory et al. (1997)	AA Only	MD & DC; Private, Nonprofit Community-based Organization	2-18	Spirituality/Church	Availability
Hurlburt et al. (2004)	N =2,823 (899 AA, 487 L, 226 O, 1,208 W)	97 U.S. Counties; Specialty MHS	2-14	Interagency Linkages; Service Types	Access Availability Utilization
Jerrell (1998)	N=4656 AA, API, L, W	CA; Public MHS	Children & Adolescents	Ethnic Match	Availability
Kataoka et al. (2002)	Three national data sets from 1996-1998	United States	3-17; Children & Adolescents	Insurance Status; Unmet Need	Utilization
Kazdin et al. (1995)	N =279 (99 AA, 180 W)	No Location Given; Outpatient MHS	3-13	Dropout Rates; Predictors of Dropout	Utilization

Citation	Sample			Issues Addressed	Direct Service Domain
	Participants	Location	Age		
Kodjo et al. (2004)	N = 3,963 (15% AA, 12% L, 67% W)	80 Urban & Rural High Schools	11-21; Grades 7-12	Access Point; Barriers & Predictors of Use	Access Utilization
Lasser et al. (2002)	73% AA, 11% L, >1% O, 15% W	United States	0-65+	Geographic Location; Service Types	Utilization
Maynard et al. (1997)	N=32,452 (1,531 AA, 900 API, 2,167 L, 1,011 NA, 26,843 W)	WA; Public, Outpatient MHS	All Ages	Intensity & Service Types	Access Availability Utilization
McCabe et al. (1999)	N=11,148 (2,539 AA, 546 API, 3,421 L, 4,642W)	San Diego County, CA; 5 Public Care Sectors	0-18	Service Types	Availability Utilization
McKay et al. (2001)	Study I: 405 (73% AA, 11% L, >1% O, 15% W); Study II: 100 (66% AA, 23% L, 4% O, 10% W)	No Location Given; Urban	3-17	Correlates of Initial & Ongoing Use	Utilization
McKay et al. (1998)	N = 109 (≈75% AA, 12% L, ≈13% W)	Inner City Child MH Agency; Low-Income	1-14	Engagement Strategies	Access
McMiller et al. (1996)	N = 192 (18% AA, 20% L, 63% W)	Southern CA; CMH Outpatient MHS	7-17; Children & Families	Help Seeking; Linkages with Other Supports; Pathways to Care	Access Availability
Pumariiega et al. (1998)	N = 2,405 (97 AA, 1,696 L, 527 W)	Coastal SE TX & Lower Rio Grande Valley; Outpatient MHS	Grades 7-12	Utilization Rates	Utilization
Ringel et al. (2001)	AA, L	US	1-17	Unmet Need	Utilization
Sturm et al. (2003)	N=45,247 (6,371 AA, 6,022 L, 1,614 O, 31,240 W)	AL, CA, CO, FL, MA, MI, MN, MS, NJ, NY, TX, WA, WI	6-17	Geographic Location; Unmet Need	Utilization
Wu et al. (1999)	N = 1,285 Pairs (AA, L, O, W)	CT, GA, NY, Puerto Rico	9-17; Children & Parent Pairs	Diagnosis	Utilization
Wu et al. (2001)	N = 206 (71 AA, 38 L, 15 O, 82 W)	Westchester County, NY	9-17	Diagnosis	Utilization
Yeh et al. (2003)	N = 1,338 (270 AA, 109 API, 372 L, 587 W)	San Diego, CA; Urban; Public, Outpatient MHS	6-17; Children & Parents	Barriers; Unmet Need	Access
Yeh et al. (2002)	N = 3,962 (714 AA, 112 API, 1,141 L, 1,985 W)	San Diego, CA; Urban; Public, Outpatient MHS	0-17	Diagnosis; Referral Source	Access Utilization
Yeh, Eastman et al. (1994)	N = 4,616 (1,219 AA, 903 API, 1,498 L, 996 W)	LA County, CA; Public, Outpatient MHS	6-17	Ethnic/Language Match	Availability

Note. AA=African American, API=Asian/Pacific Islander, L=Latino, NA=Native American, O=Other, W=White



Characteristics of the Population

The cultural/linguistic population characteristics shown in the conceptual model (Hernandez & Nesman, 2006) interact with an organization's/system's combined policies, structures, and processes. The area of compatibility represents the potential for improving outcomes by reducing mental health disparities. This section will discuss studies that examine the highlighted section of the diagram and provide pointers for enhancing compatibility.

According to the NIMH (2006), 1 out of 10 children age 18 and younger suffer from a mental disorder. Only a small percentage of children who experience mental disorders are currently having their needs met, and the percentage is much smaller for ethnically and racially diverse youth (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002; Ringel & Sturm, 2001; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). Further, half of all mental illness cases diagnosed in adults begin in adolescence (Egan & Asher, 2005). Ringel and Sturm (2001) measured the rate of unmet need for African American children at 78%. Children in particular are at greater risk of having mental health problems when socio-political factors, environmental factors, or distressing events occur in their lives or surroundings. According to SAMHSA, these factors include harmful stress, discrimination, poverty, trauma, and exposure to violence or physical abuse (U.S. DHHS, 2003). Because the African American population is considerably younger than the White population (U.S. Census Bureau, 2001b) and is more often represented among high risk populations (Sue & Chu, 2003), it becomes increasingly important to ensure that culturally and linguistically appropriate services are both available to and used by members of this population with mental health needs.

The complex socio-historical factors that can shape African American's negative interaction with health and service systems require substantial consideration on the part of mental health service providers. Health researchers focusing on cancer and HIV in African Americans have identified a generalized fear and distrust of health systems among this population, as a consequence of historical abuses committed by physicians and researchers since antebellum (Bonner, 2003). These abuses include the well-known 1932 Tuskegee Syphilis Study, in which African American men with syphilis were intentionally left untreated, as well as less publicized cases of forced gynecological experiments on slaves and the involuntary sterilizations of African American women in "federally funded health care clinics during the 1960s and 1970s" (Bonner, 2003: 20; Gamble, 1997). The collective knowledge of these experiences coupled with a history of government-sanctioned discrimination and oppression have conspired to create deep-seated attitudes that can lead to high rates of unmet need and low rates of mental health service utilization among African American families and children (Dana, 2002; McMiller & Weisz, 1996; Snowden, 1999). Further, personal experiences of institutional discrimination and a history of marginalization have been shown to increase stress levels and health risk, as well as the need for formal services (Sue & Chu, 2003; Williams et al., 2003).

Collective thought at the national level regarding racial and/or ethnic differences is often misinformed and often based on stereotypical or outdated concepts

of race (Miranda, Nakamura, & Bernal, 2003). Despite genetic and anthropological evidence to the contrary (Barbujani, Magagni, Minch, & Cavalli-Sforza, 1997; Templeton, 1998), racial categories are still often considered to be based on biological differences between human populations (Miranda et al., 2003). Evidence shows that bias in diagnoses occur frequently for racially and ethnically diverse populations (Flaskerud & Hu, 1992; Snowden 2001; Snowden, 2003; Snowden & Cheung, 1990; Worthington, 1992). For example, when compared to White populations African Americans have been shown to be over diagnosed with schizophrenia (Snowden, 2001; Snowden & Cheung, 1990). Such negative experiences with health and other service systems are often posited as causing some reluctance in help-seeking from formal providers (Broman, 1996; Dana, 2002; Saegart, 1989; Snowden, 1998; Snowden, 1999, Taylor & Chatters, 1991).

Cultural preferences also affect the help-seeking patterns of African Americans. Studies show that African Americans are more likely to turn to family members, close friends, or members of their religious community before seeking formal mental health services (McMiller & Weisz, 1996). The importance of spirituality has also been identified in the literature as an important resource used by some African Americans in dealing with mental health issues (Blank, Mahmood, Fox, & Guterbock, 2002; Broman, 1996; Brome, Owens, Allen, & Vevaina, 2000; Gregory & Phillips, 1997). Studies have shown that prayer is a common coping mechanism among African Americans (Broman, 1996), but its relationship to help seeking from formal mental health providers needs further study.

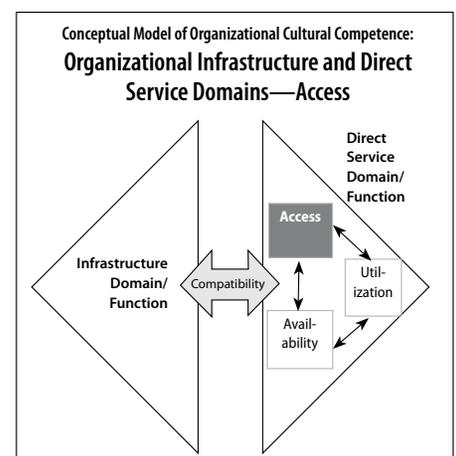
Another factor that can influence access and use of mental health services is self-esteem. A study by Gray-Little and Hafdahl (2000) found that for African Americans of all ages self-esteem scores were typically higher than Whites (with a standard deviation of 0.15). However, African American youth were shown to have lower overall self-esteem scores than White youth. These findings suggest that more research is needed to begin to determine the ways that gender and ethnicity or race affect individual's self-esteem at different ages, particularly as Gray-Little and Hafdahl (2000) note the need to understand these issues in social and psychological terms. Because lifetime mental health issues often begin in childhood, better understanding of self esteem manifestations for African American children and youth may lead to better strategies for facilitating access to mental health services.

Access to Services

Access interacts with availability and utilization to form the direct service domain. A culturally competent organization seeks compatibility between the direct service domains and the infrastructure domain to form a combined set of policies, structures, and processes that will enhance services for culturally and linguistically diverse children and families. This section will discuss studies that examine the highlighted section of the diagram and provide pointers for enhancing this compatibility.

For the purposes of this monograph, access to mental health services is defined as the direct service and organizational mechanisms that facilitate a person's ability to enter into, navigate, and exit the appropriate services and supports as need-

Despite genetic and anthropological evidence to the contrary, racial categories are still often considered to be based on biological differences between human populations.



African American youth with conduct disorders are more likely to be directed to correctional facilities than to mental health facilities (Alegria et al., 2002; U.S. DHHS, 2001).

ed. In terms of African American children and families, some of the characteristics that have been found to affect access to services include family beliefs about disease or the mental health system, types of referral patterns, and differences in pathways to care. Along with these, barriers to access such as the geographic location of clients or services, lack of information for needs recognition, and a mistrust of formal mental health systems highlight the importance of outreach and early intervention efforts to ensure that African American children and their families are aware of the range of services available to address their specific needs.

Barriers to Care

Barriers to care can occur in and across multiple levels and are affected by individual perceptions and opinions, environmental factors, and institutional policies and procedures (Hines-Martin, Malone, Kim, & Brown-Piper, 2003). Studies show that less than 4% of ethnically and racially diverse youth who have a mental health need are currently getting this need met (Cauce et al., 2002; Yeh et al. 2003). Inconsistencies in referral patterns and pathways to receiving care contribute to this unmet need (Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, & Landsverk, 2002). For instance, African American youth with conduct disorders are more likely to be directed to correctional facilities than to mental health facilities (Alegria, Canino, Rios, Vera, Calderon, Rusch, & Ortega, 2002; U.S. DHHS, 2001). Generally, more African American youth who receive mental health services enter such services involuntarily when compared to White children with similar symptoms, suggesting that mental health needs are not being addressed in culturally compatible ways (Akutsu, Snowden, & Organista, 1996; Alvidrez, 1999; Broman, 1987; Chow, Jaffee, & Snowden, 2003; McMiller & Weisz, 1996; Takeuchi & Cheung, 1998; Yeh et al., 2003).

Rates of unmet need for racially and ethnically diverse populations are considered to be important indicators of accessibility issues. Flisher, Kramen, Grosser, Alegria, Bird, Bourdon, Goodman, Greenwald, Horwitz, Moore, Narrow, and Hoven (1997) defined unmet need as psychopathology and associated functional impairment existing in the absence of mental health services for at least 6 months. They found that 17.1% of the children investigated in four sites across the United States and Puerto Rico had unmet needs (Flisher et al., 1997). They also found that being African American was significantly associated with having unmet need (Flisher et al., 1997). Other identified correlates of unmet need included family SES, child insurance status, and the psychological state of the parent of guardian (Flisher et al., 1997). These correlates suggest the importance of considering organizational infrastructure components such as the environment or climate of the organization at the point of entry, flexibility of payment structures, and staff composition as ways to reduce unmet need (Flisher et al., 1997). These findings also reiterate the need for a clear definition and understanding of the specific needs of the population being served so that practices can be changed or adapted as needed.

Kataoka, Zhang, and Wells (2002) examined national data sets for variations in unmet need according to ethnicity/race and insurance status. They found that only 6% to 7.5% of all children, aged 3-17, in the United States receive mental

health services (Kataoka et al., 2002). They also found that most youths who are in need of mental health care do not often receive services, an issue that is magnified for uninsured youths. These findings coincide with those of Flisher et al. (1997) who contend that insurance status can affect rates of unmet need for African American youth and their families. Kataoka et al. (2002) estimate that only 21% of all children who need a mental health evaluation actually receive services. For African American youths, the rate of unmet need has been estimated at 80% (Kataoka et al., 2002).

Identification of barriers that lead to unmet need must be considered in the context of culture. Yeh et al. (2003) found that the number of economic and access barriers reported by racially and ethnically diverse parents did not correlate with unmet need. The authors defined unmet need as the failure to receive specialty mental health services for twelve months (Yeh et al., 2003). Although higher levels of unmet need were reported for African Americans, fewer African American parents than White parents reported barriers even when controlling for other variables (Yeh et al., 2003). Yeh and colleagues (2003) noted limitations to the study made it more difficult to extract information regarding the barriers reported by study participants, but identified several significant implications and recommendations from the findings. One recommendation offered was that when examining self-reported barriers to mental health service use, future research should take cultural characteristics of each individual population into consideration, especially cultural influences on barrier perception, identification, and reporting (Yeh et al., 2003). Yeh et al. (2003) noted that some ethnic or racial groups may be reluctant to report negative experiences with the service system because of cultural customs or norms.

Barriers to services that have been identified include attitudes and beliefs of the parent and/or child about needs and services and time requirements associated with mental health treatments. It has been shown that parents of youth with unmet needs are more likely to think that their child would refuse services, even though it is not clear whether the child/adolescent actually feels this way (Flisher et al., 1997). Parents of children with unmet needs also report a number of common barriers, such as considerable treatment related expenses, lengthy time requirements, and lack of transportation. Suggestions for increasing accessibility and decreasing unmet need include increasing the parent's knowledge about mental health services and the mental health system and helping children and adolescents make contact with services independently of their families through established and less stigmatizing venues, such as the school system or neighborhood centers (Flisher et al., 1997).

African American adolescents have reported barriers related to knowledge of the system and need for adult support. Kodjo and Auinger (2004) examined predictors and barriers to receiving psychological services and found that African American adolescents were less likely to report receiving mental health counseling than White or Latino adolescents. Some barriers to receiving care reported by African American adolescents included lack of knowledge about where to go, not having someone to go with, and being afraid of the responses of their parents or the doctor (Kodjo & Auinger, 2004). Living in an urban area was identified as a

African American adolescents have reported barriers to care related to lack of knowledge about the system and need for adult support.

predictor for receiving mental health counseling by African American adolescents, suggesting that when services are more accessible or readily available in urban areas, adolescents will be more likely to take advantage of them (Kodjo & Auinger, 2004). Barriers reported by African American youth indicate that outreach is critical for this age group and that tailored services are needed to better accommodate and support them (Kodjo & Auinger, 2004).

Evidence for the impact of cultural differences on the intake and diagnoses phases of treatment suggests the need for clinicians to adapt to the specific needs of the clients they serve. In the absence of such adaptations, misinterpretation of symptoms or misdiagnoses can occur (Fabrega, Ulrich, & Mezzich, 1993; Kilgus, Pumariega, & Cuffe, 1995; Malgady & Constantino, 1998; Nagayama Hall, 2001; U.S. DHHS, 2001; Yeh et al., 2002). Misdiagnoses can often be attributed to a heavy reliance on a clinician's personal interpretation of symptoms, whether reported or observed (Kilgus et al., 1995). When cultural differences or clinician bias is ignored or even unrecognized as such, African American children may be denied access to appropriate mental health services.

Pathways to Care

Differing pathways into care and patterns of referral also contribute to the disparity between need and receipt of/use of appropriate mental health services for African American children and adolescents (Akutsu et al., 1996; Alvidrez, 1999; Chow et al., 2003; McMiller & Weisz, 1996; Takeuchi & Cheung, 1998; Yeh et al., 2003; Yeh et al., 2002). For example, African Americans are twice as likely as Whites to be placed in mental hospitals (Snowden, 1999; Snowden & Cheung, 1990). Furthermore, African American youths are disproportionately more likely to enter into the formal mental health system involuntarily or coercively and are more reluctant to seek help from professional mental health providers, tending to first seek help from nonprofessionals such as teachers, church leaders, or family members (Akutsu et al., 1996; Alvidrez, 1999; Broman, 1987; Chow et al., 2003; McMiller & Weisz, 1996; Takeuchi & Cheung, 1998; Yeh et al., 2003).

McMiller and Weisz (1996) examined pathways into care for children and families coming to an outpatient community mental health clinic in Southern California. When compared with White parents, African American parents were less likely to contact mental health professionals for advice or help about a child's problem (McMiller & Weisz, 1996). This was particularly evident in the initial contact phase of seeking help. African American parents were only 0.37 times as likely as White parents to contact professionals as the first step of help seeking (McMiller & Weisz, 1996). These findings suggest the importance of outreach to African Americans, who are more likely to enter the formal mental health system with a greater sense of reluctance (McMiller & Weisz, 1996). Knowing and linking with the places African American parents already go for advice can be an important form of outreach, potentially minimizing the delay of receipt of services for youths in need and reducing the chance that youths in need will enter the system through more coercive pathways. Linkages with informal support systems can also help parents and their children transition more comfortably into the idea of using mental health services (Blank et al., 2002). In cases where a youth's

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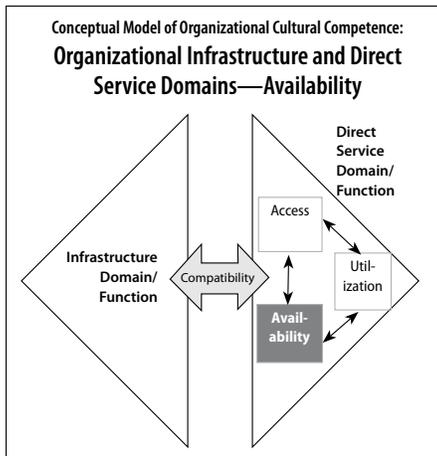
pathway into care has been coercive or involuntary, organizations may focus on developing family-therapist trust as a means for mitigating the negative impact or misgivings that can be associated with receiving formal mental health services (McKay, Stoewe, McCadam, and Gonzales, 1998).

Another way of improving pathways to care is to enhance engagement strategies with the family during the intake process. McKay et al. (1998) evaluated the impact of two engagement interventions: a telephone only intervention and telephone combined with a first interview intervention. Findings suggest that although neither engagement intervention could be linked to increasing attendance at the initial intake appointment, there was a difference in the number of therapy sessions attended. Families who were assigned the combined telephone and initial interview intervention attended 74% of the sessions, which was 25% higher than the families who were assigned the telephone only intervention. These findings suggest the importance of a therapist's engagement skills to reducing unmet need (McKay et al., 1998). A recommended strategy is for providers to develop and train staff on ways to positively influence a patient's perception of the intake process, and adopt organizational policies and procedures that support the additional time this may require.

A major challenge to increasing appropriate assessment, diagnosis, and treatment for African American youth and their families is the need for therapist awareness and outreach approaches that are responsive to characteristics of the community. Bean, Perry, and Bedell (2002) developed a series of guidelines to help service providers and organizations in supporting therapist outreach to families. Many of these guidelines address therapist outreach to a family's extended social supports and spiritual connections. For example, the authors recommend incorporating the family's religious leader into therapy sessions when appropriate and discussed beforehand with family members. Another recommended outreach method is creating therapist reports for family members unable or unwilling to attend the therapy sessions. The authors also suggest therapist home visits, which have a number of benefits, including giving the therapist a clearer idea of the family's context or allowing the therapist to engage with family members who are not present in therapy sessions. It is expected that improved engagement for African American families can increase satisfaction with the services received and strengthen therapist understanding of the families they are serving.

Although levels of need for mental health services did not vary significantly across racially and ethnically diverse populations, the review of the literature revealed high levels of unmet need for African American children and their families. These high levels of unmet need can be attributed to issues both external and internal to the family context. External to the family are issues such as policy inconsistencies, funding limitations, or lack of appropriate staff training, while issues internal to the family such as negative attitudes towards professional mental healthcare and help seeking also contribute to high levels of unmet need.

Improved engagement of African American families can increase satisfaction with services and strengthen therapist understanding of the families they are serving



Adult clients who attend racially or ethnically appropriate, specialized treatment programs have longer treatment lengths and higher return rates than those who use mainstream programs.

Availability of Services

Availability, together with access and utilization, form the direct service domains. This section will discuss studies that examine the highlighted section of the model and provide pointers for enhancing compatibility between available services and the organizational infrastructure.

Having the appropriate mental health services in place necessitates that organizations or systems consider the specific needs of African American children and their families. For the purposes of this monograph, availability is defined as having services and supports in sufficient range and capacity to meet the needs of the populations they serve. Rather than expecting African American families to adapt their lives and needs to fit the services that are already in place, services and practitioners can incorporate culture-specific knowledge and expertise into their development and operationalization of service delivery procedures and processes. Ethnic-specific mental health services and client-provider ethnic matching are two types of culture-specific expertise, whose potential positive impact have become topics of increasing importance within the field of cultural competence and mental health (Blank, Tetrick, Brinkley, Smith, & Doheny, 1994; Gamst, Dana, Der-Karabetian, & Kramer, 2004; Kurasaki, Sue, Chun, & Gee, 2000; Malat, 2001; Sue, 1998; Takeuchi, Sue, & Yeh, 1995). Another source of culture-specific knowledge and expertise for African American populations is the church and other spiritual resources (Blank et al., 2002; Brome et al., 2000; Gregory & Phillips, 1997).

Ethnic Specific Services

Several studies with African American adults have shown that the availability of ethnic specific services and client-provider ethnic matching can increase service use and length of treatment. Takeuchi et al. (1995) define ethnic specific programs as programs that are expressly designed to serve certain racial/ethnic populations. They are based in hospitals, clinics, or mental health centers and have a majority of clients from a target racial/ethnic group. Takeuchi et al. (1995) examined outcomes for ethnic specific programs and found that adult clients who attend racially or ethnically appropriate, specialized treatment programs have longer treatment lengths and higher return rates than those who use mainstream programs. A study by Blank et al. (1994) also found that treatment lengths increased when African American adults are paired with African American providers. Findings also showed that treatment lengths decrease when African American adults are paired with White providers. Malat (2001) found that African American adults were not as likely to give their doctor a high rating for respect or amount of time seen and were significantly less likely to be treated by a doctor of the same race than Whites. These findings suggest that for African American adults, the availability of ethnic specific programs, including those with provider-patient ethnic matching, could increase the use of formal services and improve the quality of the provider-patient relationship.

Research on ethnic matching in mental health services has not shown a clear link to treatment outcomes for African American children and adolescents. Some findings regarding African American youths are similar to those for adult popula-

tions in that children attending ethnic specific programs show better rates of mental health service adherence and utilization (Jerrell, 1998). Ethnic match in outpatient treatment has also been linked to reduced need for intensive services such as sub acute day treatment for African American children and adolescents (Jerrell, 1998). However, Gamst et al. (2004) found that ethnically matched African American children and adolescents did not have more positive clinical outcomes than ethnically unmatched clients. For their study, Gamst et al., (2004) considered a pair to be ethnically matched when the counselor who made the admission evaluation reported the same ethnicity as the client. For both children and adolescents, clinical outcomes due to ethnic match were not influenced when variables such as ethnicity/race, age group, referral source, and diagnosis were controlled for (Gamst et al., 2004). It is important to note that outcomes were consistently lower for all African American children compared to White children, regardless of therapist ethnicity. Further, ethnically matched African American children and adolescents made significantly fewer mental health center visits than children who were not ethnically matched (Gamst et al., 2004).

One area in which ethnic match has been shown to make a difference for adolescents is in the length of treatment (Gamst et al., 2004). Yeh, Eastman, and Cheung (1994) found that ethnic match for adolescents served as a predictor of decreased dropout, increased total length of treatment, and higher functioning scores when treatment is complete. However, among children sampled, these same predictors were not as strong, with access related variables having a greater impact. An example of an access-related variable was child eligibility for Medi-Cal, a state-funded payment program for use of health and mental health services, which also served as a marker of familial SES.

To better understand the practical application of findings on ethnic match, Gamst et al. (2004) note that it is necessary to make clear the qualifications of mental health providers and to be aware of the characteristics and needs of specific clients being served. The authors also make note that studies on ethnic matching typically omit information about professional training either in counseling or in clinical psychology. Provider training that advocates “ethno-relativistic” attitudes, cultural knowledge, and cultural competency skills may influence the delivery of mental health services to multicultural populations that have an impact as great as that of ethnic match (Gamst et al., 2004).

Spirituality and the Black Church

Spirituality is an important resource to many African American populations. Brome et al. (2000) examined the relationship of mental health and spirituality as a resource for African American women with children who were in recovery from substance abuse. The authors acknowledge the many interpretations of the concept of spirituality. Typically, spirituality has been most commonly associated with the church and organized religion, but it can also be manifested in other ways such as personal prayer, meditation, or a relationship with nature. Results from the study suggest that spirituality is linked with more positive mental health outcomes, attitudes towards family, and satisfaction with their social network. The authors note that more research is needed to better understand the impor-

It is necessary to make clear the qualifications of mental health providers and to be aware of the characteristics and needs of specific clients being served.

There are existing resources within African American communities that can be more fully utilized through better integration with formal mental health services.

While African American churches tend to have much smaller annual budgets than White churches, they offer significantly more mental health and social services to their congregants.

tance of spirituality for mental health outcomes for African American populations (Brome et al., 2000). However, these findings may suggest that there are existing resources within African American communities that can be more fully utilized through better integration with formal mental health services.

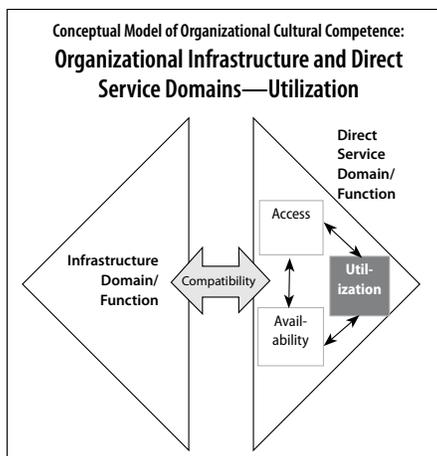
A program that has incorporated aspects of spirituality into its mental health service delivery is the Therapeutic Foster Care (TFC) program, which serves youths living in Maryland and the District of Columbia (Gregory & Phillips, 1997). TFC uses a treatment model that focuses on client empowerment through a spiritually oriented, family-focused, and culturally competent framework (Gregory & Harper, 2001; Gregory & Phillips, 1997). One way TFC uses cultural and spiritual resources is by incorporating the seven principles of Kwanza into the program, including unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith. Program evaluation outcomes show that 74% of the youths who entered the program demonstrated significant emotional improvement, 37% demonstrated academic improvement, and 90% of the parents or caregivers reported improvements in their child’s healing process (Gregory & Phillips, 1997). The positive outcomes resulting from this integration of formal mental health services and spirituality suggest the value of this resource.

The Black Church has served an important social role in African American communities throughout the history of this country, and continues to serve as an important resource that provides a number of services (Blank et al, 2002; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000) However, churches in African American communities are not often well-linked with formal health or mental health service providers (Blank et al., 2002). Blank et al. (2002) also found that while African American churches tended to have much smaller annual budgets than White churches, they offered significantly more mental health and social services to their congregants. Blank et al. (2002) recommend improving the links between churches and formal providers strongly, contending that such links are “essential to ensure appropriate, accessible, and effective health and mental health care” (p. 1672) to African American populations.

Utilization of Services

Utilization of services is the final direct service domain. This section will discuss studies that examine the highlighted section of the model and provide pointers for enhancing compatibility between the use of services and the organizational infrastructure.

Age, ethnicity, and race have been linked to patterns of utilization of mental health services (Alegria et al., 2002; Bean et al., 2002; Cheung & Snowden, 1990; Chow et al., 2003; Cuffe, Waller, Addy, McKeown, Jackson, Moloo, & Garrison, 2001; Hurlburt, Leslie, Landsverk, Barth, Burns, Gibbons, Slymen, & Zhang, 2004; Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002; Maynard, Ehreth, Cox, Peterson, & McGann, 1997; McCabe, Yeh, Hough, Landsverk, Hurlburt, Culver, & Reynolds, 1999; Pumariega, Glover, Holzer, & Nguyen, 1998; Ringel & Sturm, 2001; Snowden, 1999; Snowden & Cheung,



1990; Sue, 1999; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Yeh et al., 2002). For the purposes of this monograph, utilization is defined as the rate of use of services or their usability for populations served. Studies show that ethnicity and race are linked to utilization, but that the implications change for different age groups (Cuffe et al., 2001). For example, Cuffe et al. (2001) note that race and ethnicity are significantly associated with an underutilization of services for younger children. However, as children move into young adulthood, the differences in service utilization between African American and Whites become far less significant (Cuffe et al., 2001). A study by Ringel and Sturm (2001) reveals adolescents ages 12 to 17 are more likely than any other age group to use mental health services. This may be attributed to the inclusion of school-based services in the study's definition of the mental health system. Nevertheless, across all age groups, culturally and linguistically diverse children and families reported lower use of mental health services, even when controlled for variables such as insurance status (Ringel & Sturm, 2001).

Utilization Rates

Across all age groups, African Americans have been reported to overutilize some services and underutilize others. For example, African Americans tend to overutilize individual therapy and inpatient hospital-based psychiatric care when compared to White populations (Bean et al., 2002; Cheung & Snowden, 1990; Snowden, 2003; Snowden & Cheung, 1990; Sue, 1999; Sue et al., 1991). In contrast, when compared to White populations, African Americans have been found to underutilize outpatient, community mental health services and have been shown to use fewer treatment sessions and drop out of the mental health services at a much higher rate (Alegría et al., 2002; Coard & Holden, 1998; Hurlburt et al., 2004; Pumariega et al., 1998; Snowden, 1999; Sue, Zane, & Young, 1994). This lack of consistency in types of services and treatments used combined with higher rates of early termination of services can result in lower levels of appropriate utilization and reduced rates of improved outcomes for African Americans.

Research with African American children and adolescents also shows striking differences in rates and patterns of mental health service use compared to White populations. For example, a study in San Diego County, California found that African American children are overrepresented in the juvenile justice, mental health, child welfare, and school-based services sectors, but not the alcohol/drug treatment sector (McCabe et al., 1999). Another study found that African American youths in Washington State are more likely to receive crisis services than individual or group treatment (Maynard et al., 1997).

In a national study, Lasser et al. (2002) found that African American children had only minimally lower rates of utilization of primary health care services but substantially lower utilization rates for mental health services. In studies at various locations throughout the United States African American youths have been found to receive far fewer outpatient and specialty mental health services than Whites (Alegría et al., 2002; Hurlburt et al., 2004; Maynard et al., 1997; Pumariega et al., 1998; Yeh et al., 2002). Findings from a California study also suggest that the gender and age of the client contribute significantly to predicting use among

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Organizations and service providers should work to strengthen linkages within and across agencies as a way to strengthen the compatibility between children in need and the organizations or systems that serve them.

racial/ethnic groups, with African American adolescent females less likely to use outpatient services than African American males or White youths (Jerrell, 1998).

Intensity and Types of Services

Differences between African American and White youths have been found in the intensity of mental health services received, including the types of treatment, number of hours and episodes of care (Maynard et al., 1997; Yeh et al., 2002). Yeh et al. (2002) note that when type and intensity of treatment were considered, African American children and adolescents were less likely to receive day treatment. Furthermore, African American adolescents were less likely to receive a mental health assessment linked to special education when compared to Whites. Maynard et al. (1997) reported that African Americans received less talk therapy and drug therapy than Whites. They acknowledged that their study did not find reasons for lower rates of service use among culturally and linguistically diverse children and families, but hypothesized that institutional racism might be a significant contributor (Maynard et al., 1997).

While some studies reviewed for this monograph examined differences in rates, lengths, or patterns in services use for African Americans, others considered factors that might influence these rates and patterns in their study design or hypotheses. For example, Hurlburt et al. (2004) examined variations in utilization rates for specialty mental health services among African American children qualifying for welfare. The findings revealed that 28.3% of the children sampled from 97 counties in the United States received specialty outpatient mental health care (Hurlburt et al, 2004). Several variables acted as predictors of use, including Child Behavior Checklist (CBCL) scores, placement outside the home, child's age, and race or ethnicity (Hurlburt et al, 2004). The study found that younger children were less likely than older children to receive specialty outpatient mental health services, while African American adolescents were more likely than White adolescents to use specialty outpatient services (Hurlburt et al, 2004). Study authors also found a significant relationship between variations in service use and the degree to which agencies work together within the services system (Hurlburt et al, 2004). In counties with stronger interagency linkages, the differences between African American and White services use significantly lessened (Hurlburt et al., 2004). The findings of this study suggest that organizations and service providers should work to strengthen linkages within and across agencies as a way to strengthen the compatibility between children in need and the organizations or systems that serve them.

Diagnoses and Symptoms

A study by Yeh et al. (2002) connected issues of access with inconsistencies in service utilization by focusing on a potential linkage between patterns of use, referral source, and type of diagnoses. The authors found that African American adolescents were more likely than White adolescents to be referred for mental health services from child welfare and juvenile justice sources (Yeh et al., 2002). The study also found that African American children and adolescents were less likely to be referred by the school system for mental health services (Yeh et al.,

2002). In terms of diagnosis, Yeh et al. (2002) found that African Americans were similar to Whites across all categories except for ADHD, mood disorders, and V-codes (problems requiring clinical attention due to abuse or neglect), in which African Americans were more likely to receive a diagnosis of all three. Utilization by culturally and linguistically diverse children and families also varies by diagnosis and symptom type. Wu, Hoven, Bird, Moore, Cohen, Alegría, Dulcan, Goodman, Horwitz, Lichtman, Narrow, Rae, Regier, Roper, and Margaret (1999) examined variations in rates and types of mental health services used by children and adolescents with depressive and/or disruptive disorders. They found that African American youths were overrepresented in the group with disruptive disorders and African American children were less likely to use mental health services than Whites (Wu et al., 1999). Similarly, in a study investigating factors associated with service use for children and adolescents with depression, Wu, Hoven, Cohen, Liu, Moore, Tiet, Okezie, Wicks, and Bird (2001) found that African-American youth were less likely to receive professional assistance for depression than youth of other ethnic populations.

Yeh et al. (2002) made recommendations for organizations and policy makers to help increase utilization rates among racially and ethnically diverse populations. These included: (a) an acknowledgement of the unique needs of racially and ethnically diverse youth and a consideration for the variation in pathways to care; (b) cultural competency training that includes information about patterns of use; (c) outreach services that encourage appropriate and voluntary entry into services; and (d) research exploring whether ethnic specific services encourage voluntary entry into outpatient services.

Geographic Variation in Service Utilization

Utilization by culturally and linguistically diverse children and families has also been examined by geographic location (some examples include comparisons between high and low poverty areas and comparisons of rural and urban areas). Alegría et al. (2002) found that African Americans used significantly fewer specialty mental health services than non-Hispanic Whites, especially if they lived in Southern states and rural areas. When socioeconomic status was compared, African American participants who were not poor were less likely to receive specialty mental health services than non-poor Whites (Alegría et al., 2002). Alegría et al. (2002) also noted that it was not clear from the final data if regional differences in utilization rates were a result of differing eligibility requirements. If regional eligibility requirements significantly impact utilization rates, regional policy and system factors should be studied as potential contributors to disparities (Alegría et al., 2002). Further, racial and ethnic disparities should be examined within the context of socioeconomic status and geographic location in order to gain better understanding of factors influencing utilization.

Chow et al. (2003) found that racial and ethnic “minorities” who used mental health services were more likely than Whites to live in high poverty areas. Among African American mental health service users, 49% were living in high poverty areas compared to 10% of White service users (Chow et al., 2003). African American children living in high poverty areas were nine times more likely to

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to mental health
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use services than White children living in the same geographic area (Chow et al., 2003). African Americans were also significantly overrepresented in services in low poverty areas. Although African Americans made up 16% of the population, they represented a quarter of all mental health service users in low poverty areas (Chow et al., 2003). They also began initial service use at a younger age than Whites. However, they were more likely to enter the mental health system involuntarily, often being referred by the criminal justice system or law enforcement (Chow et al., 2003). African Americans were also more likely to use emergency services than Whites and were less likely to be self-referred or referred by a family member or close friend (Chow et al., 2003).

The Chow et al. study (2003) is significant because of its focus on mental health utilization issues within different geographic zones of a single, metropolitan city. Because the authors purposefully compared both high and low income neighborhoods, the study emphasizes the notion that families respond to mental health problems within the context of their larger social environment. A recommendation by Chow et al. (2003) urges organizations to improve outreach and increase public education as important steps towards reducing disparities for racially/ethnically diverse populations. The need for tailoring mental health services was also identified as important to meeting the specific needs of each community or population group an organization serves.

Geographic location across the United States has also been found to relate to mental health service need and utilization (Sturm, Ringel, & Andreyeva, 2003). Considerable differences were found in service use across states when compared to the national average. Unmet need was a representative characteristic of almost every geographic area examined. State-to-state usage of mental health services varied significantly from the national average of 7.5%, ranging from 5.1% in California to 11.6% in Massachusetts. In addition, need for mental health care did not match level of utilization. For example, Massachusetts had the highest mental health use rate, but the need for mental health care was below the national average. In contrast, Alabama and Mississippi had lower rates of mental health care use and higher rates of mental health need. There was also greater mental health need for African American children compared to White children, 10.6% versus 6.1% respectively, but these differences became statistically insignificant when variables such as family income, insurance status, and state residence were adjusted for. Because need for mental health services did not differ statistically across racially and ethnically diverse groups, Sturm et al. (2003) make suggestions for decreasing the gap in service utilization. The authors suggest that attention should be paid to mental health insurance mandates, managed care penetration, the supply of mental health specialists, and the role of primary care in relation to specialty mental healthcare.

Dropout Rates

Dropout from services is another aspect of utilization addressed in the literature. Kazdin, Stolar, and Marciano (1995) defined treatment dropout for children as the premature termination from therapy resulting from an independent decision on the part of the parent or family. In this study initial dropout rates

for African American families were higher than for White families and continually increased with each week of ongoing treatment (Kazdin et al., 1995). Kazdin et al. (1995) identified several predictors of early termination such as perceived parental stress, child antisocial and conduct disordered behavior, and child academic performance. Possible strategies for decreasing the early service termination for African American populations emerged from this study, including intensive outreach to families, education of parents, and increased linkages between parents, school systems, and the mental health professionals and organizations providing care.

Another aspect of utilization is treatment length, which is often linked to access issues. For example, Cuffe, Waller, Cuccaro, Pumariega, and Garrison (1995) found differences in treatment lengths for children and adolescents based on race and gender. Shorter treatment lengths were reported for African Americans compared to White populations, with 6% of African American youths receiving more than two weeks of treatment compared to 13% for White youths. African American females were treated at only one-half the rate of White males and one-third the rate of African American males. Cuffe et al. (1995) found a relationship between child and adolescent mental health service utilization rates to pathways to care, and especially to biases that may exist in the referral process. To better understand the ways in which bias manifests itself, the authors proposed that future research should focus on distinguishing between patterns of referral bias and patterns of help seeking within the African American community (Cuffe et al., 1995).

Other articles studied the relationship between African American attitudes toward professional mental health services and experiences with the system (Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2000; Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2001). Findings indicate that African Americans with major depressive episodes have more positive views of professional mental health services before seeking services than Whites but are more likely than Whites to report negative attitudes after use (Diala et al., 2000). African Americans were more likely to report positive attitudes and less embarrassment toward seeking care if a friend knew they were seeking professional help for their emotional problems before mental health services were received (Diala et al., 2000). Despite these positive attitudes, African Americans were found to use considerably fewer professional mental health services than Whites (Diala et al., 2000).

Both articles by Diala et al. (2000, 2001) urge future research to look more intensely at individual-level deterrents to using formal mental health services such as experiences of discrimination, as well as system-level access barriers. Lower African American service utilization rates and increased negative feelings toward mental health services after use were not linked to specific factors, but suggest that system-level deterrents exist. System-level barriers, identified in this and other studies, can include the cost and location of services, limited racial or ethnic match between providers and patients, or a lack of cultural responsiveness among providers.

Strategies for decreasing the early service termination for African American populations:

- Intensive outreach to families
- Education of parents
- Increased linkages between families and service systems

Parental attitudes about mental healthcare and parental discipline were both found to predict child attendance at initial appointments.

McKay, Pennington, Lynn, and McCadam (2001) described two studies that considered the factors influencing utilization rates and patterns by incorporating variables (child, family, and environmental) to test for different levels of impact on initial and ongoing service use. At the child level, no statistically significant differences were found based on age, gender, or ethnicity in predicting a child's attendance for initial and ongoing appointments. At the family level, the findings showed that higher levels of family stress and not having another adult present in the household decreased the odds of initial and ongoing attendance. More specifically at the parent level, parental attitudes about mental healthcare and parental discipline were both found to predict child attendance at initial appointments.

McKay et al. (2001) made recommendations for specific strategies that can be used to increase access and utilization of mental health services for diverse children and their families. These include: (a) examine intake procedures as a way to best develop interventions that target gaps in access and utilization; (b) provide training and guidance to providers that emphasized initial engagement with families; and (c) consider consumer input in designing a broader array of services such as group sessions, intensive outreach, or providing services at a child and/or family's natural settings (McKay et al., 2001).

The findings drawn from the literature reveal inconsistencies in utilization rates and types for African American children and their families. These inconsistencies can be better understood through the cultural competence conceptual model. An organization's degree of compatibility can be measured by the way its structures and processes work together to impede or facilitate access, availability and utilization of needed services/supports for a community's population. Thus, an organization's facilitation of access to mental health services for African Americans with persistent rates of high unmet need, is a goal that is directly linked to encouraging more appropriate utilization rates and the cultural competence of mental health providers.

Highlights

The African American population in this country is diverse and often, misunderstood (Greico & Cassidy, 2001; Williams & Jackson, 2000). The Black or African American census category can include individuals of diverse ethnic backgrounds with distinct cultural histories and even languages, despite the fact that the majority are native born and speak English primarily (McKinnon & Bennett, 2005; Williams & Jackson, 2000). Researchers have identified a generalized distrust and fear of health systems and treatments among African Americans that has been attributed to the population's distinct experience with slavery, state-sanctioned discrimination, and abuse on the part of researchers and physicians (Bonner, 2003; Gamble, 1997). Despite the challenges associated with such historical experiences, African Americans tend to place great importance on family and kin networks, as well as spirituality in dealing with health and mental health issues (Blank, Mahmood, Fox, & Guterbock, 2002; Broman, 1996; Brome, Owens, Allen, & Vevaina, 2000; Gregory & Phillips, 1997; McMiller & Weisz, 1996).

A total of four evidence-based strategies for working with African American children and/or adolescents and their families were identified from the articles reviewed in this chapter. One strategy related specifically to mental health service access, two addressed availability issues, and one related to service utilization. McKay et al. (1998) identified strategies that were effective in increasing access through targeted engagement and outreach efforts. Targeted engagement and outreach to African American families and extended supports can encourage use of services and facilitate interaction with the mental health system, especially where issues of mistrust or misunderstanding of the service system exist. Yeh and colleagues (2003) recommend the use of ethnic specific services and ethnic matching as being effective strategies in service availability, leading to decreased dropout, increased length of treatment, and improved outcomes when treatment was completed (Yeh, Takeuchi, & Sue, 1994). African American children and families should be given the option to select therapists with whom they feel comfortable. The incorporation of spiritual beliefs and practices in treatment, when appropriate and requested by families is also recommended (Gregory & Phillips, 1997). Finally, service providers are encouraged to appropriately identify and refer children with mental health need in ways that are culturally acceptable and supportive to family members (Yeh et al., 2002).

Our analysis of the research literature resulted in identification of a number of direct service strategies recommended for enhancing compatibility between African American populations and the mental health service system. Recommendations of direct service strategies for use with African Americans are summarized below and presented in table form in Appendix A. For each direct service domain presented, issues related to compatibility between population characteristics and organizational characteristics are linked with evidence based strategies.

African American children and families should be given the option to select therapists with whom they feel comfortable.

Recommended service delivery strategies for

increasing African American access to services include:

- Promote diversity in staff composition, including state or region of origin and socioeconomic background
- Self-assess for bias and discrimination in procedures and actions
- Train staff in specific engagement strategies for a positive intake experience
- Develop community access points through schools, recreational, or religious organizations

Service Access Recommendations

The African American population is diverse, including variety in socioeconomic status, geographic location, religious preferences, and family makeup. Key barriers to mental health service access that have been identified for African American families relate to the local infrastructure and include expenses, time required to receive treatment, and transportation. Access can be facilitated by finding out about local barriers from consumers, community leaders, and programs that link with and know the characteristics, needs and resources of the population. Service delivery strategies to meet the needs of a diverse African American population that emerged from our analysis of the literature include:

- Investigate and tailor mental health services to meet the needs of each community, population group, or individual served
- Promote an environment that appreciates diversity at the point of entry
- Address transportation needs and flexible scheduling
- Develop flexibility in payment structures
- Promote diversity in staff composition, including state or region of origin and socioeconomic background

Experiences of institutional discrimination, marginalization and bias can result in decreased trust in formal providers and increased stress for many African American families. These experiences act as barriers to access when they result in reluctance to seek formal help. However, the trust families place in informal networks of support and spiritual resources can serve as an important link to seeking mental health services. The literature points to the importance of strategies that increase trust and link informal to formal services. Themes that emerged from our analysis of the literature include:

- Self-assess for bias and discrimination in procedures and actions
- Conduct outreach to extended family, friends, and religious communities
- Train staff in specific engagement strategies for a positive intake experience
- Allow for time to develop trust during interactions with families

Access for African American children and families is also impacted by experiences with involuntary referrals, reliance on emergency services, and punitive reactions to problems that arise. This is compounded by a lack of knowledge about services, lack of support in getting to services voluntarily, and fear of stigma. However, there is some evidence that many African Americans have more positive attitudes toward seeking professional mental health services for certain conditions such as major depressive episodes. Therefore, if organizations understand the help-seeking process better and learn the reasons for which African American families would seek formal services, better strategies for engagement could be developed. Specific emergent themes suggest that organizations:

- Develop community access points through schools, recreational, or religious organizations
- Link youths/families with someone they feel comfortable talking to about what they are experiencing

Another way to address overrepresentation of African American children in involuntary and punitive services is to increase access to information about symptoms and available services for different levels of need. Although there is often a lack of trust in and unwillingness to seek help from professional mental health providers, many African American families do trust the advice of family members, close friends and religious leaders. The literature suggests providing information in ways that are acceptable to families, such as:

- Conduct outreach to families and informal supports with information about needs recognition and the array of services and treatments available to meet different levels of need
- Create linkages between parents, schools, informal, and formal mental health services

Service Availability Recommendations

African American churches often provide mental health services and social services. However, many African American churches are not linked with formal mental health providers and their services are not funded by typical means such as Medicaid. The literature suggests that racial/ethnic specific programs and provider-patient racial/ethnic matching can increase the use of formal services, improve the quality of the provider-patient relationship, and increase length of treatment use. In addition, addressing spirituality can result in more positive mental health outcomes, attitudes towards family, and satisfaction with social networks. However, providing preferred services is made difficult by the scarcity of African Americans in formal mental health professions. Themes in the literature suggest the need for organizations to increase availability of acceptable services through:

- Create linkages with churches and religious groups to smooth transitions between formal and informal services.
- Integrate spiritual resources into organizational structures, values, and direct service interventions.

It is also important to recognize that preferences for racial/ethnic-matching may differ for African American children and adolescents compared to adults. Race/ethnic match for adolescents has been shown to decrease dropout, increase total length of treatment, and improve functioning scores. African American children attending race/ethnic specific programs also show better rates of mental health service adherence and utilization, and reduced need for intensive services. However, racially/ethnically matched children have not shown more positive clinical outcomes than unmatched clients. For adults, who often influence whether or not children enter services, race/ethnic specific programs and race/ethnic matching can increase the use of formal services and improve the quality of the provider-patient relationship. Based on this evidence, it is suggested that organizations:

- Assess the child and family's preference for race/ethnic match and conduct on-going assessment of effectiveness of the match
- Ensure cultural competency of all providers
- Promote the development, growth, and sustainability of race/ethnic specific services and providers

Recommendations for increasing the availability of services for African American populations include:

- Create linkages with churches and religious groups to smooth transitions between formal and informal services
- Integrate spiritual resources into organizational structures, values, and direct service interventions
- Assess the child and family's preference for race/ethnic match and conduct on-going assessment of effectiveness of the match
- Ensure cultural competency of all providers
- Promote the development, growth, and sustainability of race/ethnic specific services and providers

Recommendations for increasing utilization of services among African Americans include:

- Gather and use consumer input to design the array of service types and improve outreach, engagement, and retention
- Identify and eliminate biases in the referral, diagnoses, and treatment processes
- Provide needed services in the child and/or family's natural settings
- Promote development of family-therapist trust by connecting to informal support systems, incorporating the family's religious beliefs, and conducting home visits
- Collect consumer input about experiences with services on an on-going basis

Service Utilization Recommendations

It is clear from the literature that African Americans have higher rates of early termination of services and shorter treatment lengths. Some factors having an impact on utilization include having only one adult present in the household, having high levels of stress, or difficulty with disciplining children. These barriers are compounded by negative experiences at intake. Since positive parental attitudes about mental health care and comfort with child discipline are associated with increased attendance at initial appointments, it is suggested that organizations:

- Provide training and guidance to staff emphasizing initial engagement with families, including strategies to decrease stress, accommodate the time requirements placed on a single parent, and avoid judgments about child discipline
- Identify gaps in the types or timing of services that are utilized by developing intake procedures that assess for them without bias
- Gather and use consumer input to design the array of service types and improve outreach, engagement, and retention

Of great concern is that dropout rates from mental health services for African American families are higher than for White families and continue to increase with each ongoing week in treatment. This has been linked to experiences of discrimination, with negative feelings toward mental health services increasing after using them. Specific strategies organizations can develop to address these issues include:

- Identify and eliminate biases in the referral, diagnoses, and treatment processes
- Provide needed services in the child and/or family's natural settings
- Distinguish between patterns of referral bias and patterns of help seeking that affect types and intensity of services received
- Reduce system-level barriers, such as cost and location of services, limited options for ethnic match, or a lack of culturally competent providers
- Promote development of family-therapist trust by connecting to informal support systems, incorporating the family's religious beliefs, and conducting home visits
- Collect consumer input about experiences with services on an on-going basis

Based on the definition of organizational cultural competence developed for this monograph, increasing knowledge about the African American populations served in a particular community and applying this knowledge to direct service policies and procedures may have the potential to reduce disparities. Specific strategies brought out in this literature review can be applied immediately, while further research is needed to identify additional strategies that can assist in developing cultural competence in mental health services for African American populations.

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3

Research with Asian and Pacific Islander Populations

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Asian and Pacific Islander Populations

The previous chapter provided the research base for examining the degree of compatibility between African American children and families and the mental health service system. Organized by the conceptual model detailed in Chapter 1, this chapter will similarly analyze population characteristics and compatibility with the mental health system for Asian and Pacific Islander (API) populations in the United States.

Background

Within the research literature, Asian Americans and Pacific Islanders are at times regarded as a single group and at others as two separate groups. U.S. Census data are presented separately for each group in this chapter to better understand the diversity that exists within this large ethnic category.

Asian Americans

The U.S. Census Bureau defines Asian Americans as “people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. . .Asian groups are not limited to nationalities, but include ethnic terms, as well” (Barnes & Bennett, 2002, p. 1). In 2000, there were 17 Asian racial/ethnic groups recognized in U.S. Census data reports, each with their own unique cultural and linguistic characteristics. According to the U.S. Census Bureau, the Asian population totaled 10.2 million or about 3.6% of the national population in 2000 (U.S. Census Bureau, n.d.b). An additional 1.7 million people identified themselves as being a combination of Asian and one or more other races, yielding a U.S. Asian population total of 11.9 million or 4.2% (U.S. Census Bureau, n.d.b).

According to a press release by the U.S. Census Bureau (2004a), the Asian population is growing at a rate significantly faster than the White population. From 2000 to 2003, the Asian population grew 12.5%, compared to a growth rate of 0.9% for the White population. While all Asian groups have steadily increased in population size, those with the highest growth rates (over 100%) from 1990 to 2000, were Bangladeshi, Pakistani, Asian Indian, Sri Lankan, Indonesian, and Taiwanese Americans (Asian & Pacific Islander American Health Forum [APIAHF], n.d.). U.S. Census Bureau projections suggest that by 2050, the Asian population will triple. This means that the Asian population will experience a 213% growth rate, compared with a 7% growth rate for the White population within the same time frame (2004b).

In 2000, there were 17 Asian racial/ethnic groups recognized in U.S. Census data reports, each with their own unique cultural and linguistic characteristics. By 2050, the U.S. Asian population is expected to triple in size.

The U.S. Census Bureau recognizes 12 racial and ethnic groups as being Native Hawaiian and Other Pacific Islanders. Among these are Polynesian, Micronesian, Melanesian, and Other Pacific Islander.

Census data regarding per capita income and poverty rates are helpful when examining broad trends, but are more difficult to apply to the Asian population as a whole, because of the socioeconomic diversity that exists within this population. According to the 2000 U.S. Census, the average per capita income was \$21,587. The average per capita income for White Americans ranked significantly higher at \$24,819 per year, while the average for Asians was slightly less than the national average at \$20,719 per year. However, within group differences were profound. The per capita income levels for Hmong, Tongan, Cambodian, and Laotian Americans were each under \$11,500, with the Hmong American per capita income at \$6,613. This can be contrasted with Taiwanese, Japanese, Asian Indian, and Sri Lankan Americans, whose per capita income was calculated at over \$25,000 (APIAHE, n.d.).

Further, the U.S. Census identified 13% of the Asian population as living below the poverty line, compared to 8% of the White population and 12% nationally. The 2000 U.S. Census poverty line guidelines were based on the 1999 federal poverty levels set at \$8,501 for an individual and \$17,029 for a family of four. Considerable differences in poverty level percentages become apparent when compared across Asian groups. For example, only 7% of Filipino Americans and 9% of Japanese Americans were living below the federal poverty line in 2000. These population groups were significantly less likely to be living in poverty than Hmong, Cambodian, and Bangladeshi Americans, whose likelihood of living in poverty was 38%, 29%, and 23% respectively (APIAHE, n.d.).

Nearly half of the Asian American population lived in the western United States, followed by the Northeast at 20%, the South at 19%, and the Midwest at 12% in 2000. Just over half of the Asian population lived in three states: California, Hawaii, and New York.

Native Hawaiian and Other Pacific Islanders

The U.S. Census Bureau recognizes 12 racial and ethnic groups as being Native Hawaiian and Other Pacific Islanders. Among these are Polynesian, Micronesian, Melanesian, and Other Pacific Islander (U.S. Census Bureau, n.d.a). In 2000, the Native Hawaiian and Other Pacific Islander population was almost 400,000, or .1% of the national population (U.S. Census Bureau, n.d.b). An overwhelming number of Native Hawaiian and Other Pacific Islanders identify with more than one ethnic/racial group. An additional 475,000 people, or .2% of the national population, identified themselves as being a combination of Native Hawaiian and Other Pacific Islander and a combination of one or more other races (Grieco, 2001).

Similar to growth trends for the Asian population, projected growth rates for Native Hawaiians and Other Pacific Islanders are also considerable. According to a press release by the U.S. Census Bureau (U.S. Census Bureau, 2004a), the Native Hawaiian or Other Pacific Islander population is growing at a rate significantly faster than the White American population. From 2000 to 2003, the Native Hawaiian population grew 5.8%, compared to a growth rate of 0.9% for the White population (U.S. Census Bureau, 2004a). The Native Hawaiian and Other Pacific Islander

groups with the highest growth rates from 1990 to 2000 were the Samoan and Tongan populations, each growing by more than 100%. There was also considerable growth within Fijian and Guamanian/Chamorro groups, which grew 93% and 88% respectively (APIAHE, n.d.).

U.S. Census data regarding per capita income and federal poverty rates for Native Hawaiian and Other Pacific Islanders are easier to interpret than similar data regarding Asians. This is because there are fewer extreme highs and lows in socio-economic status seen across the Asian population. According to data from the 2000 U.S. Census, Native Hawaiian and Other Pacific Islanders had an average per capita income of \$14,773, considerably lower than the Asian American per capita income of \$20,719. Significant variations were found when Native Hawaiian and Other Pacific Islander groups were compared. Tongan Americans were at the lowest end of the spectrum with a per capita income of \$9,975 and Native Hawaiians at the highest end with a per capita income of \$15,554 (APIAHE, n.d.).

The U.S. Census identified 17% of the Native Hawaiian and Other Pacific Islander population as living below the poverty line. There were variations in poverty level percentages when specific Native Hawaiian and Other Pacific Islander populations were examined, however the variations were not as pronounced as they were within the Asian population. At the high end were Samoan Americans, 20% of which lived below the federal poverty line in 2000. At the low end were Fijian Americans, 11% of which lived below the poverty line (APIAHE, n.d.).

Similar to Asian Americans, the largest percentage (73%) of Native Hawaiian and Other Pacific Islanders lived in the West, followed consecutively by the South, Northeast and Midwest regions. More than half (58%) of Native Hawaiian and Other Pacific Islanders lived in two states: California and Hawaii. Over 80% of Hawaii's population reported being Asian, Native Hawaiian, or Other Pacific Islander in 2000 (APIAHE, n.d.).

Defining the Population

Despite the population's significant projected growth rate, mental health systems have been slow to respond to the cultural and linguistic needs of the Asian American, Native Hawaiian, and Other Pacific Islander populations. This can be attributed in part to a lack of uniformity in the way data about this population are presented (Chin, n.d.; National Asian American Pacific Islander Mental Health Association [NAAPIMHA], n.d.). In particular, there is a lack of uniformity in the way this population is defined within mental health research and across various state, local and private mental health organizations.

In 1997, the Federal Office of Management and Budget (OMB) changed the way the Federal government is required to present ethnicity and race information to better reflect the diversity in the United States. This change recognized Asians and Native Hawaiian or Other Pacific Islanders as distinct racial/ethnic groups, and these standards were adopted for the 2000 U.S. Census (U.S. Census Bureau, n.d.a). While these changes increase the categorized diversity of the United States population, it becomes more difficult to compare current data with historical data. For example, the Surgeon General's Report (U.S. Department of

There is a lack of uniformity in the way the Asian American and Pacific Islander population is defined within mental health research and across various state, local, and private mental health organizations.

Few large-scale studies

have examined mental health need specific to Asian American and Pacific Islander populations, and when conducted, such studies often use a limited sample size or are confined within a narrow geographic location.

Health and Human Services [U.S. DHHS], 1999) and the 1990 U.S. Census (U.S. Census Bureau, 2002) were conducted before the OMB changes and recognized only four racial and ethnic groups in the United States. In these reports, Asians and Native Hawaiians or Other Pacific Islanders were considered together and defined as Asian Americans and Pacific Islanders (AAPI).

There is also a lack of consensus in the ways Asian and Native Hawaiian or Other Pacific Islander populations are defined within the context of mental health research. Many of the articles reviewed for this report did not identify whether Native Hawaiians or Other Pacific Islanders were a specific subset of the population sampled. Other articles included and studied both populations together. For the purposes of this monograph, we will consider the Asian American and Native Hawaiian or Other Pacific Islander populations together and when appropriate address this racial/ethnic group as Asian/Pacific Islanders (APIs) to recognize the geographic and cultural breadth of this population.

Mental Health and Prevalence Rates

Prevalence rates for mental disorders among API populations remain difficult to estimate for a number of reasons (Sue & Chu, 2003; Takeuchi & Kramer, 2002; U.S. DHHS, 2001). In an editorial published in the *Western Journal of Medicine*, Takeuchi and Kramer (2002) note that much of the available information regarding prevalence rates and patterns of service use for APIs were obtained from hospital treatment records that limit the generalizability of findings. In addition, studies measuring API representation rates for specific types of service venues cannot always accurately account for the number of people with needs who are not using services (Takeuchi & Kramer, 2002). Prevalence rates are also difficult to determine because large national studies such as the Epidemiological Catchment Area Study (ECA) and the National Comorbidity Survey (NCS) have typically used such a small API sample that generalizations or estimates are not possible.

Few large-scale studies have examined mental health need specific to APIs, and when conducted, such studies often use a limited sample size or are confined within a narrow geographic location. The Chinese American Psychiatric Epidemiological Study (CAPES) was a five-year study funded by the National Institute of Mental Health (NIMH) that represented the first major epidemiological study for any API group. However, the CAPES sample included only Chinese American adults living in Los Angeles County between 1993 and 1994, of which 90% were immigrants (U.S. DHHS, 2001). Another example of an epidemiological study with a limited sample size was the Filipino American Community Epidemiological Study (FACES), a four-year study conducted in California and Hawaii and funded by the National Institute of Alcohol Abuse and Alcoholism. Although these studies provided useful data about the specific groups studied, generalizations and recommendations for broad-level application were difficult to make.

Additional studies have examined prevalence within specific populations and/or regions of the United States. For example, some studies have focused on symptoms and diagnoses related to API populations in Hawaii that contributed to a better understanding of statewide service needs. One study identified gender differences

in the prevalence of depression, anxiety, aggression, and substance abuse (Makini, Andrade, Nahulu, Yuen, Yates, McDermott, Danko, Nordquist, Johnson, & Waldron, 1996). Specifically, Native Hawaiian girls showed higher mean scores for these conditions than Native Hawaiian boys (Makini et al., 1996). The researchers concluded that higher aggression scores paired with higher substance abuse scores suggested Native Hawaiian girls are more likely to demonstrate externalizing symptoms than Native Hawaiian boys (Makini et al., 1996). Another study focusing on Filipino American adolescents, also conducted in Hawaii, found that Filipino American respondents did not report higher levels of symptoms of depression when compared with White adolescents (Edman, Andrade, Glipa, Foster, Danko, Yates, Johnson, McDermott, & Waldron, 1998). However, similar to the findings of Makini et al. (1996), gender differences were found, with Filipino American females experiencing higher levels of depressive symptoms than males (Edman et al., 1998). The authors suggest that Hawaii's unique cultural landscape, notably the lack of a single ethnic majority, is an important factor to consider in interpreting findings (Edman et al., 1998). Due to regional differences in populations, infrastructures, and policies, additional localized research is needed to better inform mental health services for the diverse API populations in the United States.

Findings

Overview of Articles Reviewed

Only 14 research articles reviewed for this monograph included API children and families within study samples. The majority of articles (10) were published between 1994 and 1999, and the remaining four were published between 2000 and 2004. The study samples are summarized in Table 2 and described in this section.

Half (7) of the 14 articles included in this review focused on API populations exclusively, while six included API, African American, and Latino populations. One article also included Native Americans. It was difficult to assess which API groups were included in a particular study's sample, especially if other groups were also included. Studies that examined only API populations were typically clearer in their definitions of the populations included. API representation in the overall sample was often so small that generalizations were difficult. The percentage of APIs included in study samples ranged from 1.63% to 8.15%, and the number of API participants ranged from 109 to 1,275.

During the review process, a number of studies were found that addressed the issue of ethnic matching for adult populations, but very few focused on children and adolescents. Four articles that included youth populations in study samples (3 AA, API, L and 1 API Only) were included in this review. Findings from these studies (Gamst, Dana, Der-Karabetian, & Kramer, 2004; Jerrell, 1998; Yeh, Eastman, & Cheung, 1994; Yeh, Takeuchi, & Sue, 1994) were difficult to generalize because all four studies took place in California.

More than half (8) of the research articles that included API populations were based in California or the western coast of the United States. In addition, three research articles drew samples from Hawaii, while one article was based in New York. Only one article utilized a national sample.

Due to regional differences in populations, infrastructures, and policies, additional localized research is needed to better inform mental health services for the diverse Asian American and Pacific Islander populations in the United States.

Table 2
Summary of Literature Review Articles: Asian/Pacific Islander

Citation	Sample			Issues Addressed	Direct Service Domain
	Participants	Location	Age		
Chow et al. (2003)	N =78,085 (23,683 AA, 1,275 API, 19,849 L, 33,278 W)	NYC, NY; Urban	All Ages	Socio-Geographic Location	Utilization
Edman et al. (1998)	N =385 (270 API [F], 115 W)	HI; Rural	14-19	Psychiatric Symptoms	Characteristics of the Population
Jerrell (1998)	N =4656 (AA, API, L, W)	CA; Public MHS	Children & Adolescents	Ethnic Match	Availability
Lau et al. (2000)	N =3178; API Only (539 C, 394 F, 316 J, 506 K, 591 Other API, 832 SEA)	LA County; Public, Outpatient MHS	All Ages	Ethnic Specific Services	Availability
Leong (1994)	API (C, J, F), W	HI; Public, Inpatient & Outpatient MHS	All Ages	Pathways to Care	Access
Makini et al. (1996)	N =1918; API (NH) Only	HI; Rural & Urban	Grades 9-12	Psychiatric Symptoms	Characteristics of the Population
Matsuoka et al. (1997)	API, W (1986 Survey Data)	U.S.	All Ages	Utilization Rates	Utilization
Maynard et al. (1997)	N =32,452 (1,531 AA, 900 API, 2,167 L, 1,011 NA, 26,843 W)	WA; Public, Outpatient MHS	All Ages	Intensity & Service Types	Access Availability Utilization
McCabe et al. (1999)	N =11,148 (2,539 AA, 546 API, 3,421 L, 4,642W)	San Diego County, CA; 5 Public Care Sectors	0-18	Service Types; Utilization	Availability Utilization
Yeh et al. (2003)	N =1,338 (270 AA, 109 API, 372 L, 587 W)	San Diego, CA; Urban; Public, Outpatient MHS	6-17; Children & Parents	Barriers; Unmet Need	Access
Yeh et al. (2002)	N =3,962 (714 AA, 112 API, 1,141 L, 1,985 W)	San Diego, CA; Urban; Public, Outpatient MHS	0-17	Diagnosis; Referral Source	Access Utilization
Yeh, Eastman et al. (1994)	N =4,616 (1,219 AA, 903 API, 1,498 L, 996 W)	LA County, CA; Public, Outpatient MHS	6-17	Ethnic/Language Match	Availability
Yeh, Takeuchi et al. (1994)	N=912; API Only	LA County, CA; Outpatient MHS	0-18	Ethnic Match	Availability
Ying et al. (1994)	N=1731; API Only (C, F, K, J, SEA)	LA County, CA; Public, Outpatient MHS	All Ages	Representation Rates	Utilization

Note. AA=African American, API=Asian/Pacific Islander, C=Chinese, F=Filipino, J=Japanese, K=Korean, L=Latino, NA=Native American, NH=Native Hawaiian, SEA= South East Asian, W=White

Characteristics of the Population

The cultural/linguistic population characteristics interact with an organization's/system's combined policies, structures, and processes. The area of compatibility represents the potential for improving outcomes by reducing mental health disparities. This section will discuss studies that examine general characteristics associated with API population.

Most documents reviewed for this monograph acknowledged that the API population is very diverse and requires targeted study. A report by the APIAHF notes that the API population in the United States comes from nearly 50 countries and speaks over 100 different languages and dialects (n.d.). It has also been pointed out that using blanket terms such as “Asian American,” “Native Hawaiian or Other Pacific Islander,” or “Asian American/Pacific Islander” fails to convey the diversity of national origin and linguistic backgrounds unless explicitly explained (Gong, Gage, & Tacara, 2003). Many have pointed out that it is especially difficult to generalize the mental health needs of the API population as a whole because of the diversity in socioeconomic status, acculturation level, and nations of origin (Gong et al., 2003; Leong & Lau, 2001; Sue & Morishima, 1982; Uehara, Takeuchi, & Smukler, 1994).

The relative youth of this population compared to the White population is one characteristic relevant to issues of cultural competency and mental health service delivery. Nearly one third of the API population is 19 years of age or younger (Huang, Lee, & Arganza, 2004). Other characteristics of the API population that may affect access and use of mental health services include language, loss of face, and immigration and acculturation factors. These and other API population characteristics need to be taken into consideration along with community context to reduce disparities in access, availability and utilization of services.

Language

Linguistic barriers are common within API populations and are linked to issues of access, underutilization, and misdiagnosis (Flaskerud & Liu, 1990; Gong et al., 2003; Sue & Sue, 1990). According to 2000 census data compiled and reported by the APIAHF, 36% of Asian American and 12% of Native Hawaiian or Other Pacific Islanders report having Limited English Proficiency (LEP). More than 4 million APIs speak a non-English language at home and assess their own English speaking ability at less than “not very well.” Many of the populations with the highest percentages of LEP are also those that have been experiencing the fastest population growth rates. For example, Bangladeshi and Taiwanese Americans were among the fastest growing Asian descent populations in 2000, and just over 50% of each population self reported as LEP. Among Vietnamese Americans, whose population grew 99% from 1990 to 2000, 61% of respondents classified themselves as LEP. Overall, 25% of all Asian American households and 6% of Native Hawaiian or Other Pacific Islander households were reported to be “linguistically isolated,” defined by the Census Bureau as individuals over the age of 14, speaking a non-English language at home, and speaking English less than “not very well” (APIAHF, n.d., p. 14). The populations with the



Linguistic barriers have been shown to affect the ways in which people seek health and mental health care, as well as the quality or effectiveness of care received.

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highest percentages of linguistic isolation were Vietnamese Americans at 45%, Korean Americans at 39%, and Taiwanese Americans at 38%.

Linguistic barriers have been shown to affect the ways in which people seek health and mental health care, as well as the quality or effectiveness of care received (Choi & Wynne, 2000). Choi and Wynne (2000) report that communication difficulties resulting from language barriers and an inadequate array of translation services were identified by mainstream service providers as being a significant barrier to providing comprehensive services to APIs with developmental disabilities. Organizations can benefit from becoming familiar with the linguistic capacities of the populations they serve prior to experiencing the growth that is anticipated in census reports.

Loss of Face

A cultural factor that has been shown to limit help seeking and use of formal mental health services for many API populations is the idea of “shame,” or “loss of face” (Gong et al., 2003; Kramer, Kwong, Lee, & Chung, 2002; Sue, 1994). This concept is found in many cultures across the world but is especially significant for many API groups. For Japanese Americans this concern is called “Haji.” For Filipino Americans it is named “Hiya” and for Chinese Americans, “Mentz,” (Sue, 1994). Loss of face refers to the way that a person is perceived by others in society as well as the way individuals feel their character is being threatened or lost (Gong et al., 2003). Concern with loss of face indicates that a person worries about not being respected, and fears being shamed or publicly embarrassed by a situation.

Fear of loss of face can impact the level of care received by API children and youth experiencing emotional/behavioral challenges because it acts as a deterrent to seeking mental health services. Gong and colleagues (2003) found that a concern with loss of face significantly decreased help seeking behaviors for mental health services among Filipino Americans. However, a decrease in help-seeking for general health services was not found, suggesting that these services may be more acceptable. Kramer et al. (2002) found that for API youth, loss of face can occur when a child does not meet the plans or expectations of the family, and this loss of face extends beyond the child to include the family (Kramer et al., 2002). The influence that loss of face may have on help-seeking behaviors for both child and family suggests it should be an important consideration in outreach and engagement with API communities.

Immigration and Acculturation

A person’s acculturation level, personal or familial experiences with immigration, and family history are important components to consider when serving API populations. The concept of acculturation, initially developed within the field of anthropology, was subsequently adopted within the field of psychology. In its original conception, acculturation was defined as the result of first hand contact between differing cultures and changes that occur for each culture as a result (Redfield, Linton, & Herskovitz, 1936). In a broader sense, acculturation can be thought of as the process of cultural, economic, and political adaptations in

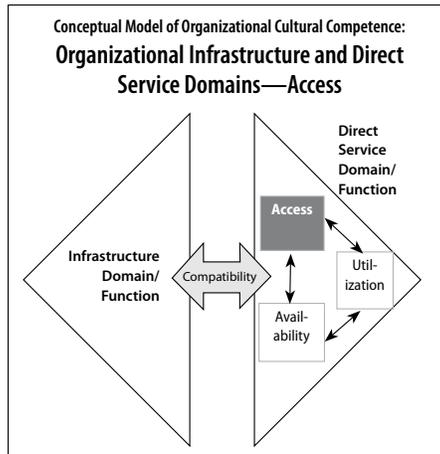
perceptions, values, and behaviors, which can occur when a single person or immigrant group moves to or comes in contact with those in a new country.

Acculturation has been shown to affect API attitudes toward help seeking and use of the formal mental health care system (Leong & Lau, 2001; Spencer & Chen, 2004; Sue, 1994; Sue, 1998). For API immigrants and refugees, adjusting to life in the United States requires a number of adaptations, such as changes in educational pursuits, the way business is conducted, how religion is expressed, and how language is used. Often formal services and supports do not provide adequate or appropriate support or assistance to immigrant populations as they make these adaptations.

Many APIs, especially recent United States immigrants and refugees, also have different ideas about what constitutes mental wellness and what is needed to recover from mental illness (Sue, 1994). Highly acculturated APIs have been shown to have beliefs that accommodate formal help seeking and are more accepting of mental health services than less acculturated APIs (Leong & Lau, 2001). It is postulated that, since culture influences the way people think about symptoms and diseases, APIs who are more fully integrated into mainstream American culture may be more likely to consider the symptoms they are experiencing from a Western medical perspective. Evidence for differences in beliefs about the service system are also seen in the types of barriers to care reported by API parents of different acculturation levels (Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). Yeh et al. (2003) found that non-Hispanic White parents and more acculturated API parents reported more barriers to receiving care than less acculturated API parents. Among API parents, those who were less acculturated to the United States reported more linguistic barriers than acculturated parents (Yeh et al., 2003).

Because of the impact of acculturation and other cultural factors, adaptations are needed in the types of services offered, how the family is involved in them, and the ways in which they are delivered for specific families. An important consideration is the role of the immediate and extended family in shaping individual identities and the degree to which family members provide daily support to one another. API families and family networks may be larger than those of White Americans and may be based to a greater extent on cooperation and emotional support (Agbayani-Siewert, 1994; Lin & Cheung, 1999). Further, the individual child and family's culture and level of acculturation may vary significantly, especially among families that include members from several countries of origin, languages, and acculturation levels. For instance, family-centered therapy has been shown to be an effective strategy for working with Filipino Americans (Agbayani-Siewert, 1994; Lin & Cheung, 1999). However, the findings did not support the use of family-centered therapy with other API populations, some of who may consider it invasive for family members to participate in the treatment process. Because of the diversity found within the API population, findings such as these are difficult to generalize and should not be extended to other sub-groups within the population (Lin & Cheung, 1999). Differences between API sub-groups should be acknowledged and understood in order to more effectively plan and deliver services to this population.

Because of the impact of acculturation and other cultural factors, adaptations are needed in the types of services offered, how the family is involved in them, and the ways in which they are delivered for specific families.



Access to Services

Access interacts with availability and utilization to form the direct service domains. A culturally competent organization seeks compatibility between the direct service domains and those of the infrastructure domains/functions to form a combined set of policies, structures, and processes that will enhance services for culturally and linguistically diverse children and families. This section will discuss studies that examine the highlighted section of the figure and provide pointers for enhancing compatibility.

It is important to consider both cultural and historical influences when examining barriers to accessing mental healthcare services for API children and their families. For the purposes of this monograph, access has been defined as the direct service and organizational mechanisms that facilitate a person's ability to enter into, navigate, and exit the appropriate services and supports as needed. Key access barriers identified across the literature that relate to API populations include differences in needs recognition and a hesitancy to enter into the formal mental health system. These access barriers suggest a need for intensive outreach efforts, with an emphasis on making API children and families aware of and comfortable with formal mental health services.

Barriers to accessing mental health care for API populations are not well understood, although high levels of unmet need have been verified. It has been shown that less than 4% of ethnic and “minority” youth who have mental health needs currently have this need met (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002; Yeh et al., 2003). Unmet need is generally characterized as the gap between clinically assessed need and the use of formal service. Yeh et al. (2003) found higher levels of unmet need for API populations than for non-Hispanic White populations, but found a lack of correlation between the number of barriers reported by API parents and the level of unmet need. As noted earlier, both non-Hispanic White and API parents who had higher levels of acculturation reported more barriers, while those who had lower levels of acculturation reported fewer barriers. Yeh et al. (2003) also found that previous use of mental health services was not linked to identification of barriers, suggesting that the perception of barriers was more closely related to cultural and historical factors. Although such factors were not explicitly discussed, the authors suggest that diverse groups may be reluctant to report barriers for a number of reasons. These reasons may include: an unwillingness to voice complaints because of cultural value for suffering silence and/or a respect for authority, a lack of desire to seek services due to associated stigma, or identifying services in this country as highly favorable despite problems when compared to the limited services in countries of origin (Yeh et al., 2003). In addition to lack of information about the influence of such cultural factors on barrier endorsement, the applicability of study findings to specific API groups was considered to be limited (Yeh et al., 2003). The authors point out that the sample included Filipino Americans, Cambodian Americans, Laotian Americans, and Korean Americans but did not study differential needs within these groups. It is recommended that future research on access to services systematically study the influence of culture on perception of barriers, and that alternatives to self report measures be developed.

Help Seeking

API youths and families have been shown to have lower rates of help-seeking when compared to the U.S. population as a whole (Abe-Kim, Takeuchi, & Hwang, 2002). Help seeking is defined as looking for assistance with emotional or behavioral problems from mental health services and other formal and informal supports (Srebnik, Cauce, & Baydar, 1996). Lower rates of help seeking may be attributed to higher rates of unrecognized need, not knowing where to go, not knowing what services are available, and a higher reluctance to enter the formal system. Numerous studies show that API populations have consistently underutilized mental health services, yet far less is known about help seeking predictors among API populations (Abe-Kim, Takeuchi, & Hwang, 2002; Bui & Takeuchi, 1992; Cheung & Snowden, 1990; Gong et al., 2003; Kung, 2004; Leong, 1994; Lin & Cheung, 1999; Matsuoka, Breaux, & Ryujin, 1997; Sue & Sue, 1990; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Zhang & Snowden, 1999; Zhang, Snowden, & Sue, 1998).

Historically, API populations have been referred to as “model” ethnic populations that require fewer mental health and social services (Lin & Cheung, 1999; Sue & Morishima, 1982; Yamashiro & Matsuoka, 1997). However, research has shown that low use of formal mental health services does not necessarily translate to an absence of need (Uba, 1994; Zhang et al., 1998). Although few studies address help-seeking behaviors among API youths, studies that examine help-seeking among adult populations attribute high levels of unmet need to a hesitancy to seek formal mental health services rather than a lack of need (Uba, 1994; Zhang et al., 1998). In addition, the literature indicates that when APIs seek professional psychological services it is often late in the help seeking process and generally viewed as a last resort or the result of involuntary referrals from criminal justice or social services (Akutsu, Snowden, & Organista, 1996; Lin & Cheung, 1999). These studies indicate the importance of outreach strategies that increase knowledge about mental health and the positive benefits of accessing mental health services early.

The low levels of help-seeking among API populations have been documented across many types of services (Zhang et al., 1998). For example, a study conducted in Los Angeles found that significantly fewer API respondents had visited a mental health center, psychiatric outpatient clinic at a hospital, self-help group, or “folk therapist” (i.e., spiritualist or herbalist) therapist than White respondents (Zhang et al., 1998). API respondents were also less likely to mention mental health symptoms to a friend, religious leader, mental health professional, or physician, and reported fewer somatic symptoms than did White respondents (Zhang et al., 1998). Reports of somatic symptoms predicted more openness about mental distress, but there was no difference in openness identified for API and White respondents.

Researchers have identified factors linked to the help-seeking process. For example, a study of the willingness of Chinese, Japanese, and Korean college students to seek treatment or recommend treatment to a friend found both culture specific and non-culture specific factors to be important (Barry & Grilo, 2002). Nearly half of the participants in this study reported an intense unwillingness to seek professional mental health treatment, and nearly one third reported an

Low use of formal mental health services among Asian Americans and Pacific Islanders does not necessarily translate into absence of need.

Studies have linked

help-seeking patterns for API groups to specific cultural influences such as fear of loss of face, English proficiency, and acculturation level.

Findings suggest the importance of assessing level of acculturation and forming linkages with informal systems and interpreters to facilitate access to formal mental health services for API populations.

unwillingness to recommend formal mental health services to friends (Barry & Grilo, 2002). Culture-specific variables associated with willingness to seek or recommend treatment included acculturation levels, ethnic identity, and English proficiency. Students who were more willing to seek treatment were more assimilated, had independent self-construal, and preferred low interpersonal distance (Barry & Grilo, 2002). Students who were willing to recommend that a friend seek treatment were also more independent and preferred low interpersonal distance, but were found to have stronger ethnic identities (Barry & Grilo, 2002). Non-culture specific variables that were linked to greater willingness to seek or recommend treatment were indicators of psychological distress such as feelings of personal inadequacy, and demographic variables such as being female, being older, and having spent less time in the United States (Barry & Grilo, 2002). Although more needs to be learned about the complex factors related to help-seeking for different API populations, findings from Barry and Grilo (2002) indicate that mental health providers could increase access for API populations by promoting culture-specific factors that direct individuals toward seeking and recommending services to their family and friends.

Some studies have linked help-seeking patterns for API groups to specific cultural influences such as fear of loss of face, English proficiency, and acculturation level. A study focusing on Filipino populations found that linguistic barriers and concerns about loss of face had a great impact on the help-seeking process for this group (Gong et al., 2003). Gong et al. (2003) found that 75% of participants had not used any type of mental health care, and an informal system was the most frequently used sector of care. Respondents who had higher levels of concern about loss of face had a lower probability of seeking out specialty mental health services (Gong et al., 2003). In contrast, respondents who were bilingual or English-only speakers were found to be less reliant on an informal system and less reluctant to use formal mental health services (Gong et al., 2003). These findings suggest the importance of assessing level of acculturation and forming linkages with informal systems and interpreters to facilitate access to formal mental health services for API populations.

API help-seeking patterns are also influenced by factors such as insurance status (Spencer & Chen, 2004), and family stress or conflict (Abe-Kim et al., 2002). Abe-Kim et al. (2002) found that API adults who experienced high levels of family conflict had a greater likelihood of seeking formal mental health services compared to informal services. In this case the presence of family conflict served as a greater predictor of seeking formal help than did language, stigma associated with mental health, or knowledge of available services (Abe-Kim et al., 2002). While informal services were found to be an important resource for the Chinese American sample studied, families that were experiencing greater stress were more likely to seek formal services (Abe-Kim et al., 2002). The use of informal services was more likely to be attributed to a lack of knowledge about available formal mental health services (Abe-Kim et al., 2002). These findings highlight the importance of assessing multiple factors, including the level of stress and conflict in API children and families when they enter services and the need to engage families earlier in the help-seeking process.

Pathways to Care

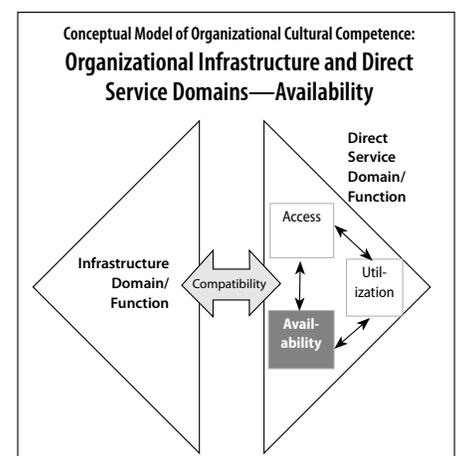
Pathways to care have been found to vary both by geographic location and by API population. In Hawaii, differences were found in the ways Chinese and Filipino Americans enter the mental health system (Leong, 1994). Chinese Americans were more likely than Whites to be referred to services by a family member or friend than to be self-referred and were more likely than Whites to be referred by social institutions or the police/court system. Similarly, Filipino Americans were more likely than Whites to be referred by the police/court system and less likely to be self-referred (Leong, 1994). Filipino Americans were also more likely to be referred by medical personnel and less likely to be referred by other mental health professionals (Leong, 1994). Examination of referral differences for Japanese Americans yielded no significant differences from White populations (Leong, 1994). Such reported differences in referral patterns in Hawaii suggest the importance of assessing how different groups of API children and families are entering services in a particular community.

Pathways to care have also been associated with representation in different sectors of care. Findings of one study showed that API children were underrepresented in the mental health, child welfare, and school services sectors, but were represented at expected rates in alcohol and criminal justice sectors (McCabe, Yeh, Hough, Landsverk, Hurlburt, Culver, & Reynolds, 1999). A reason for concern is that the sectors of care in which differences were seen between API and White populations were associated with involuntary entry. Others have also reported that API youths are more likely than White youths to enter services through involuntary or coercive means such as child welfare or law enforcement (Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, & Landsverk, 2002). Yeh and colleagues (2002) recommended that future research should examine the impact of acculturation as well as differences in service use among API subgroups. Because of these differences, it is also recommended that outreach services promote voluntary entry into services by API populations. One area of research that may assist in this goal is to examine the role of ethnic specific services in voluntary entry and earlier identification of need.

Availability of Services

Availability, together with access and utilization, form the direct service domains. This section will discuss studies that examine the highlighted section of the figure and provide pointers for enhancing compatibility between availability of services and the organizational infrastructure.

Having appropriate mental health services in place requires organizations and systems to make available an array of services designed to meet the specific needs of racially/ethnically diverse children and their families. Rather than expecting API families to adapt their lives and needs to fit already established services, organizations and practitioners can incorporate culture-specific knowledge and expertise into their processes of planning and coordinating services (Sue, 1998). For the purposes of this monograph, availability is defined as having services and supports in sufficient range and capacity to meet the needs of the populations they serve.



Several studies offer strong support for the implementation of culturally and ethnically tailored services for Asian American and Pacific Islander populations of all ages.

Ethnic Specific Services and Ethnic Match

Ethnic specific services and client-provider ethnic matching are two types of culture-specific expertise that have can help increase the cultural competence of mental health providers (Kurasaki, Sue, Chun, & Gee, 2000; Sue, 1998). The NAAPIMHA (n.d.) advocates for the adoption of such culturally appropriate interventions and services. For API populations who do not speak English, linguistically appropriate services bridge communication barriers that typically render mainstream services unusable or ineffective. Clients who are racially or ethnically matched with their therapist may be more prepared to work in therapy because they feel more at ease (Pope-Davis, Toporek, Ortega-Villalobos, Ligiero, Brittan-Powell, Liu, Bashur, Codrington, & Liang, 2002). In addition, therapists are more likely to understand the sociopolitical context of their patient if they are racially and/or ethnically matched (Pope-Davis et al., 2002). Research shows that the training and employment of bilingual and bicultural professional personnel and the development of ethnic specific interventions may be particularly important in communities that have limited resources for API families (Akutsu, Tsuru, & Chu, 2004; Pope-Davis et al., 2002; Sue, 1998).

Several studies identified through this literature review offer strong support for the implementation of culturally and ethnically tailored services for API populations of all ages. Many of the studies focused specifically on whether ethnic or cultural matching between a client and mental health professional increased service use and length of treatment (Akutsu et al., 2004; Fujino, Okazaki, & Young, 1994; Takeuchi, Sue, & Yeh, 1995; Ying & Hu, 1994). Such studies often examined ways in which racially/ethnically specific services, such as client-therapist matching, have an impact on adult API populations. For example, when outcomes for adults using ethnic specific programs in Los Angeles were examined, results revealed that clients attending these specialized treatment programs experienced longer treatment lengths and higher return rates than those who used mainstream programs (Takeuchi, Sue, & Yeh, 1995).

Client-therapist match has also been positively associated with initial attendance at intake appointments, lower dropout rates, and increased satisfaction among API populations of all ages (Akutsu et al., 2004; Fujino, Okazaki, & Young, 1994; Ying & Hu, 1994). In Los Angeles County, having a racial/ethnic match between a client and therapist was shown to increase service use for Southeast Asians (Ying & Hu, 1994). Akutsu et al. (2004) focused on identifying predictors for attendance of intake appointments using a sample including five API groups. They found a positive association between factors such as an adult client's need for immediate care or desire for a more expedient initial appointment, having a language match with the prescreening interviewer, and the assignment of the prescreening interviewer as the intake therapist attendance at an initial appointment (Ying & Hu, 1994).

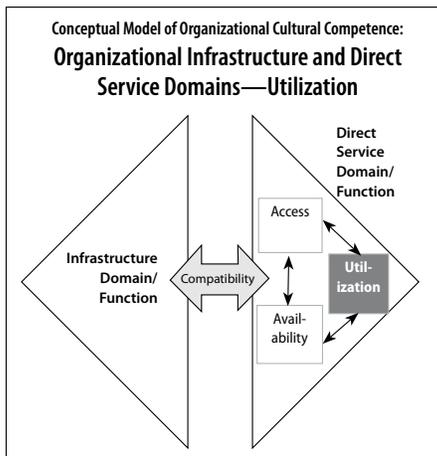
The importance of matching on gender as well as ethnicity has also gained some support. Fujino et al. (1994) found that females who were gender and ethnically matched were 20 times less likely to drop out of treatment compared to those who were not matched at all. This study by Fujino et al. (1994), which

focused on API women, showed that clients whose gender and ethnicity matched their therapist had the lowest rates of dropout at 0.6%, compared to a 5.8% dropout rate for clients who were ethnically matched only. Dropout rates for clients without either ethnic or gender matches were significantly higher, at 18%. Even when variables such as linguistic need were controlled for, the effects of gender and ethnic matching were still significant, including greater satisfaction with services and improved mental health functioning (Fujino et al., 1994).

Lau and Zane (2000) compared treatment outcomes for ethnic specific and mainstream mental health services by investigating rates of utilization and cost analyses. Their findings indicated that API consumers of all ages who used ethnic-specific services stayed in treatment for longer periods of time than those who used mainstream services. Though this increased use was associated with an increased cost of operation, it was also linked with improved treatment outcomes (Lau & Zane, 2000). In contrast, increased utilization was not associated with better treatment outcomes for those API consumers who used mainstream services (Lau & Zane, 2000). These findings support the importance of having ethnic-specific services available to decrease disparities in API populations.

Although ethnic specific services and ethnic matching have been shown to be effective within general and adult API populations, more research is needed to determine their effectiveness in increasing access for API children and adolescents. Children attending ethnic specific outpatient programs have shown better rates of mental health service adherence and utilization and reduced the need for intensive services such as sub acute day treatment (Jerrell, 1998; Yeh, Eastman, et al., 1994; Yeh, Takeuchi, et al., 1994). Additionally, children and adolescents who receive ethnic specific services show better functioning scores and better outcomes (Yeh, Takeuchi, et al., 1994). Ethnic match has also been linked to decreased dropout, increased total length of treatment, and higher functioning scores for both children and adolescents (Yeh, Takeuchi, et al., 1994). However, ethnic match was not as closely linked to these outcomes for children, due to the greater influence of other access related variables such as eligibility for Medi-Cal, a state-funded payment program for use of health and mental health services, which served as a marker of familial SES (Yeh, Takeuchi, et al., 1994). Nevertheless, Gamst et al. (2004) suggest that studies about ethnic matching in adults hold relevance for youth populations because adult family members are so often involved in the care of the child. When findings about adult and youth populations are considered together, the research regarding ethnic specific services has significant clinical and organizational implications and may provide guidance for planning ethnically and culturally specific services. However, a gap in research focusing on API youths exists and needs to be addressed.

The research regarding ethnic specific services has significant clinical and organizational implications and may provide guidance for planning ethnically and culturally specific services.



Utilization of Services

Utilization of services is the final direct service domain. This section will discuss studies that examine the highlighted section of the figure and provide pointers for enhancing compatibility.

Central to this study is the premise that an assortment of culturally and linguistically appropriate services and supports must be made available and work together with research-based, culturally competent strategies to increase utilization of appropriate mental health services for children and families. For the purposes of this study, utilization is defined as the rate of use of services, or their usability for populations served.

API populations have a history of low service utilization (Bui & Takeuchi, 1992; Cheung & Snowden, 1990; Gong et al., 2003; Kung, 2004; Leong, 1994; Lin & Cheung, 1999; Matsuoka et al., 1997; Sue & Sue, 1990; Sue et al., 1991; Zhang et al., 1998). Utilization issues for the total population are related to help seeking strategies and beliefs about mental illness, as well as responses of the service system to their needs (Lin & Cheung, 1999; Sue & Morishima, 1982; Yamashiro & Matsuoka, 1997; Zhang et al., 1998).

Utilization Patterns and Rates

Mental health service utilization research remains limited for API children and adolescents. However some insights can be gained from published research that targets the entire population. Matsuoka et al. (1997) examined mental health service utilization rates for APIs of all ages in an effort to determine whether national patterns of utilization exist. Consistent with other studies (Bui & Takeuchi, 1992; Cheung & Snowden, 1990; Gong et al., 2003; Kung, 2004; Leong, 1994; Matsuoka et al., 1997; Sue & Sue, 1990; Sue et al., 1991; Zhang et al., 1998), the authors found that with little exception, national utilization of services for API populations were considerably lower than for Whites (Matsuoka et al., 1997).

The research literature specific to API youths indicates differences in representation according to the sector of care utilized. Findings indicate that API youths are underrepresented across mental health, child welfare, and serious emotional disturbance (SED) sectors, but are represented at the expected rates within alcohol and criminal justice (McCabe et al., 1999). Other findings show that API youths are more likely to be referred to services from child welfare agencies (Yeh et al., 2002). Gender and age of the client contributes significantly to use, with adolescent females less likely to use outpatient services than males and younger clients (Jerrell, 1998).

Geographic Location

Much of the research specific to API children and families is limited to certain geographic regions of the country. This level of specificity is useful for the populations and regions studied but may be less applicable to API populations elsewhere. For example, a study conducted in Los Angeles County (Ying & Hu, 1994) shows that Filipino Americans are underrepresented and Southeast Asians

are overrepresented in mental health services. In Hawaii, Chinese, Japanese, and Filipino Americans have all been shown to underutilize inpatient mental health services when compared to White populations (Leong, 1994). Chinese and Japanese Americans also underutilize outpatient services in Hawaii compared to White populations (Leong, 1994). Underutilization was considered to occur when a population's representation in a mental health facility was less than their representation in the general population.

Maynard, Ehreth, Cox, Peterson, and McGann (1997) studied differences in the utilization rates of public mental health services for racial and ethnic groups in Washington State. Significant differences in utilization rates were found for all racial and ethnic groups. APIs were more likely to use individual therapy, group therapy, and medication management and less likely to use crisis services (Maynard et al., 1997). However, Chow, Jaffee, and Snowden (2003) found that APIs living in high poverty areas of New York City were much more likely to use emergency services. Additionally, API mental health service users were significantly more likely to use public mental health services and less likely to be enrolled in Medicaid compared to White service users in New York (Chow et al., 2003). These differences point to the importance of considering the community context and populations served to understand utilization patterns and address disparities.

Diagnoses

In terms of diagnosis and utilization types, API youths have been found to be less likely than White youths to receive a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) (Yeh et al., 2002). They are also less likely to receive a mental health assessment linked to special education, but are more likely to be assigned a V-code (a label largely related to child abuse) (Yeh et al., 2002). Recommendations have been made that potentially target all levels of care including administration, policymaking, and direct service. Yeh et al. (2002) suggest acknowledgement that the needs of “minority” youth are unique and appropriate pathways into care for these populations must be developed. Cultural sensitivity training regarding utilization patterns and diagnostic differences is also recommended, and future research should consider if ethnic specific services increase voluntary entry into mental health services (Yeh et al., 2002).

When discussing barriers to appropriate mental health services, Leong and Lau (2001) suggest that many difficulties related to evaluation and diagnoses are culturally rooted, whether on the part of the clinician or in the translation of symptoms. On more than one level, therapist bias or a lack of complete understanding can become an impediment to providing mental health services to APIs. The client's expression of symptoms may be based on a set of cultural beliefs that may differ greatly from the interpretation arrived at through Western diagnostic assessment strategies (Leong & Lau, 2001). A therapist's cultural influences may also explain differences in clinical diagnosis. When describing Li-Repac's (1980) investigation into therapist judgment of symptoms, Leong and Lau (2001) found that Chinese clinicians viewed White patients as demonstrating more severe pathology than did White clinicians. Additionally, White clinicians were more inclined to label Chinese patients as being depressed or inhibited than were

Many difficulties related to evaluation and diagnoses are culturally rooted, whether on the part of the clinician or in the translation of symptoms.

Findings emphasize the importance of having mental health providers acknowledge the diversity within Asian and Pacific Islander populations.

Chinese clinicians (Leong & Lau, 2001). The authors suggest that future research should examine the factors contributing to API underutilization of mental health services and the factors that influence how APIs enter into the service system (Leong & Lau, 2001). Differences in assessment based on the ethnicity of the clinician point to the need for adaptations such as training, consulting with cultural experts, or tailoring instruments to the populations served.

Highlights

Findings of this literature review emphasize the importance of acknowledging the diversity within Asian American and Pacific Islander populations. The broad range in socioeconomic status, acculturation levels, languages, and nations of origin needs to be understood and addressed in every aspect of service design and delivery. In spite of the great diversity across API populations, mental health services are generally underutilized due to cultural factors that need to be recognized by mental health providers. These cultural factors influence a number of aspects that can determine whether API children and families reach needed services, including need recognition, help-seeking behaviors, and engagement in services.

A total of six evidence-based strategies were identified in the studies reviewed for this chapter, for use by providers who serve API children and their families. Two strategies were related to service access, three to service availability, and one to service utilization. Barry and Grilo (2002) identified culture-specific variables associated with increased help seeking and access to services including level of acculturation, ethnic identity, and English proficiency. Individuals who were more acculturated were more likely to seek mental health services or recommend them to friends in need (Barry & Grilo, 2002). In their work with Filipino Americans, Gong et al. (2003) also found that culture-specific variables that influenced the help seeking process. Such findings highlight the importance of getting to know a target population and understanding the ways in which cultural factors may affect help-seeking behaviors. Ethnic match was identified as an effective means for increasing the use of available services among API children and families (Lau & Zane (2000); Yeh et al., 2003; Ying & Hu, 1994). Finally, service providers are encouraged to appropriately identify and refer children with mental health need in ways that are culturally acceptable and supportive to family members (Yeh et al., 2002). Such efforts are particularly important in cases where “loss of face” or differences in the identification of symptoms may result in decreased use of services.

The research literature reviewed in this chapter identified a number of direct service strategies to enhance compatibility between API populations and the mental health service system. Recommendations of direct service strategies for use with Asian Americans/Pacific Islanders are summarized here and presented in table form in Appendix B. For each direct service domain presented, issues related to compatibility between population characteristics and organizational characteristics are linked with evidence based strategies.

Service Access Recommendations

To increase access to services for API populations, it is important to assess and develop culturally sensitive outreach to families and informal networks to increase awareness of and comfort with formal services. This is especially important in reducing the number of API families that enter services under great stress or through coercive means such as referrals from the courts. For example, there is a need for immediate attention and quick access to a bilingual/bicultural staff member who can initiate a relationship during the intake process and engage the family in services. Access strategies to meet the needs of a diverse API population that emerged from our analysis of the literature include:

- Increase API family and community knowledge regarding the positive benefits of mental health services and develop strategies to facilitate voluntary and earlier entrance into services
- Maintain familiarity with linguistic capacities of the populations in the community to develop services that meet emerging interpretation needs
- Assess level of acculturation and link with informal systems and interpreters
- Assess pathways to care, including referrals from self, family member or friends, primary health care, schools, child welfare and police/court systems
- Link with primary health care in identification and early intervention for mental health needs
- Address perceived barriers to care and beliefs about mental health of parents and children
- Adapt the environment at the point of entry, including staff bilingual/bicultural intake staff and strategies to reduce the fears and stress of children, parents, and caregivers

Service Availability Recommendations

Studies about ethnic matching for API adults hold relevance for youth populations because adult family members are often involved in the care of the child. When findings about adult and youth populations are considered together, the research regarding ethnic specific services has significant clinical and organizational implications and may provide guidance for planning ethnically and culturally specific services.

API children attending ethnic specific programs show better rates of mental health service adherence and utilization, reduced need for intensive services, better functioning scores, and better outcomes at termination. Recommendations for service provision that emerged from our analysis of the literature include:

- Assess outcomes and satisfaction with services on an individual and group basis to determine preferences and need for ethnic match
- Ensure the availability of ethnic and linguistic match between therapist and family, including matching on immigration/refugee experiences when possible

Recommended service delivery strategies for increasing access to services for Asian and Pacific Islander populations include:

- Maintain familiarity with linguistic capacities of the populations in the community to develop services that meet emerging interpretation needs
- Assess level of acculturation and link with informal systems and interpreters
- Link with primary health care in identification and early intervention for mental health needs
- Address perceived barriers to care and beliefs about mental health of parents and children

Strategies for increasing the availability of services for Asian and Pacific Islander populations include:

- Ensure the availability of ethnic and linguistic match between therapist and family
- Provide a comprehensive array of supports including linkages with informal systems, and interpreters that can bridge linguistic and cultural barriers

- Provide a comprehensive array of supports including linkages with informal systems, and interpreters that can bridge linguistic and cultural barriers.
- Assess the effectiveness of ethnic specific interventions with parents as well as children served
- Train bi-lingual and bicultural personnel to promote their professional development
- Promote and develop ethnic specific interventions in communities where API families and youth live
- Track attendance, treatment lengths, and return rates for API clients and compare ethnic matched and mainstream providers

Service Utilization

Overall, API families underutilize formal mental health services. However, utilization rates may differ by geographic location and social/cultural characteristics. Therefore it is important to understand the composition and utilization patterns of local populations and to assess the unique needs of API families. Based on findings and analysis of the literature review it is recommended that providers:

- Acknowledge that needs of culturally and linguistically diverse children and families are unique and appropriate pathways into care for these populations must be developed
- Track differences in utilization rates and patterns by geographic location, sector of care, access to insurance, and demographics to assess gaps
- Include in cultural competence training information about utilization patterns for API populations and strategies for improving these patterns.
- Make cultural adaptations to assessment procedures through consulting with cultural experts, tailoring instruments, and training staff

Recommendations for Future Research

Additional research is needed to better adapt service provision to API populations. It is important to gather information about characteristics of local populations as well as understanding national trends. Yeh et al. (2003) recommend improving assessment of barriers through considering cultural influences on responses to surveys. Additional information is also needed about the ways in which ethnic specific services and ethnic match improve early intervention and utilization of services (Yeh et al., 2002). In addition, much remains to be understood about age, acculturation level, and gender differences in the preference for ethnic specific services and/or ethnic matching.

There is also a need for studies of mental health need using larger API population samples and wider geographic distribution. A lack of consensus about how API populations are defined and represented in data collection limits the generalizability of mental health research. Work is needed to develop consensus in the ways the Asian and Native Hawaiian or Other Pacific Islander populations are defined within the context of mental health practice across sectors and national, state, and local levels. Developing consensus will assist in assessing the level of disparities and the specific populations of API families that have greater unmet need. It will also assist in generalizing findings of studies that provide evidence for the effectiveness of specific strategies.

Strategies for increasing the utilization of services for Asian and Pacific Islander populations include:

- Acknowledge that needs of culturally and linguistically diverse children and families are unique
- Track differences in utilization rates and patterns
- Include in cultural competence training information about utilization patterns for API populations and strategies for improving these patterns
- Make cultural adaptations to assessment procedures through consulting with cultural experts, tailoring instruments, and training staff

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4

Research with Latino Populations

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Latino Populations

This chapter will present the current research base for examining the degree of compatibility between Latino children and their families and the mental health service system. The findings are presented based on the conceptual model described in Chapter 1.

Background

Latinos are the fastest growing segment of the nation's population. According to the U.S. Census, Latinos totaled 35.3 million or about 13% of the total U.S. population, growing by 57.9% between 1990 and 2000 (Guzmán & Diaz McConnell, 2002). The total increase in the population accounted for 30.8% of the country's growth in 2000 (Chavez, 2004). The current growth rate means that by 2050, 31% of all children will be Hispanic, compared to 43% for Whites and 16% for African Americans (Board of Children and Families, 1995). According to the U.S. Census Bureau:

People who identify with the terms "Hispanic" or "Latino" are those who classify themselves in one of the specific Hispanic or Latino categories ... "Mexican," "Puerto Rican," or "Cuban"—as well as those who indicate that they are "other Spanish, Hispanic, or Latino." Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Spanish, Hispanic, or Latino may be of any race (n.d.).

The largest group within the Latino population is of Mexican origin—accounting for 59% of the total U.S. Hispanic population. Puerto Ricans make up nearly 10% of this population, while Cubans account for roughly 4% of the population. Individuals with origin in Central or South America account for just over 9% of the population. The smallest groups reported were Dominicans, representing 2.3% of the population and Spaniards at 0.3% of the population. Nearly 16% of individuals identified as "Other Hispanic" in the U.S. Census did not specify one of the categories above.

Sixty percent of Latinos were born in the United States. The remaining 40% migrated to this country for reasons such as political instability in their home country, increased economic opportunities, access to better educational opportunities, and/or family reunification. Latinos who migrate to this country often do so to join family members who are already here. Overall, Latinos tend to be younger and have lower educational levels than the White population. Thirty-six

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percent of the Latino population was 18 years or younger in 2000, and over half were younger than 26 years of age (Brindis, Driscoll, Biggs, & Valderrama, 2002). According to the U.S. Census, the median household income for Hispanic families was \$33,676 in 1999. The per capita income for Hispanic households, however, was only \$12,111. Further, 22% of the population was recorded as living below the poverty level. When compared to the White population, Hispanics have low educational attainment levels. According to the 2000 Census, 41% of U.S. Hispanics aged 18 or older had graduated with a high school diploma compared to 70% of Whites. Further, only 10% of Hispanics aged 25 years or older had received a bachelor's degree by the last census count.

Despite the frequent characterization of Latinos as being a single ethnic group, great variety exists within the U.S. Hispanic population. Notable differences are demonstrated in a range of practices, preferences, and experiences, including: geographic settlement patterns, language preference, religious practices, racial identity, level of education, and socioeconomic status. In addition, there is a wide variety in the degree of continued contact that individuals may have with their countries of origin. Latinos born in this country or those with extended settlement in this country, for instance, may have little or no direct contact with their countries of origin. Further, individuals born outside of the United States bring diverse histories and experiences from their home countries. For instance, some individuals may have rural/agrarian upbringings, while others migrate from suburban or large metropolitan areas. Still others may have fled their home countries as refugees from political violence or persecution. Wide variations are also reflected in socioeconomic backgrounds, educational attainment, and job/career opportunities within the country of origin.

Studies of Latinos in this country often focus on the importance of familism within the population (Burnette, 1997; Vega, 1995). Research on the familistic nature of Latinos emphasizes the importance of internal family dynamics and communication, social networks and the distribution of resources, the preservation of cultural traditions and norms, and immigrant family resettlement patterns. Studies also reflect changes in family dynamics and gender roles in response to what Vega identifies as “continuous cultural interchange, syncretism, and adjustments as human groups respond to new environmental circumstances and structural inequalities” (1995, pp. 3-4; see also Burnette, 1997). Changes in socioeconomic status that occur with migration and resettlement may result in changing patterns of household composition, such as tri-generational households with grandparents (often grandmothers) who contribute to childcare and the family economy, single-parent households, or increased cohabitation versus marriage (Burnette, 1997). When conducting research with Latino families, it is imperative to acknowledge and address the social and economic conditions that have contributed to such changes within Latino families in this country (Burnette, 1997).

The concept used to examine the impact of the migration process on Latinos and other immigrant populations was originally developed within the field of

anthropology. Acculturation was defined as the result of “having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” and was thought to encompass changes occurring in various social spheres, i.e., economics, politics, and cultural traditions (Redfield, Linton, & Herskovitz, 1936, p.149). Subsequent work in anthropology and psychology identified and outlined the process of acculturation at the individual level, known as psychological acculturation (Berry, Wintrob, Sindell, & Mawwhinney, 1982; Graves, 1967; Tropp, Erkut, Coll, Alarcón, & Vázquez García, 1999). Psychological acculturation produces changes in values, attitudes, behaviors, and ultimately, identity (Graves, 1967; Williams & Berry, 1991). Early studies on acculturation in the field of psychology highlighted negative consequences among immigrants undergoing this process (Malzberg & Lee, 1956). Over time, frameworks have been developed for measuring the relationship between acculturation and mental health (Berry & Kim, 1988; Williams & Berry, 1991).

The term acculturative stress was developed to refer to the specific stressors that are a direct consequence of the acculturation process experienced by immigrants, including “lowered mental health status...feelings of marginality and alienation, heightened psychosomatic symptom level, and identity confusion” (Berry, Kim, Minde, & Mok, 1987, p. 492). Within Latino families, stresses often occur when children develop into adolescents, learn English, and become part of U.S. peer cultures (DeVos & Suarez-Orozco, 1990; Gibson, 1989; Hernandez & Nesman, 2004; Jose-Kamfner, 1994; Lucas, 1997; Phelan, Davidson, & Yu, 1991; Rumbaut, 1994; Santisteban, Szapocznik, & Kurtines, 1995; Smart & Smart, 1995; Szapocznik & Fein, 1995). This period of time is often marked by adolescents being ashamed of their parents’ language, dress, foods and employment (Rumbaut, 1994). The resulting estrangement between adolescents and their families has been linked to antisocial behaviors such as drinking, drug abuse, school misbehavior, school drop out, and teen pregnancy (Aronowitz, 1988; Rumbaut, 1994; Santisteban et al., 1995; Szapocznik & Fein, 1995; Vega, 1993; Vega, 1995).

Latinos and Mental Health

Despite the dramatic growth in the population, the mental health research literature related to Latinos has a number of gaps (Castro & Ramirez, 1997; Vega & Lopez, 2001). In a review of research literature on Latino mental health services, Vega and Lopez (2001) noted the lack of definitive methods to estimate unmet need among Latino children, equivalence problems with regard to the measurement of problem behaviors and symptoms, and a lack of accurate estimations of national prevalence rates. A review of epidemiological surveys and clinical studies with adults in California (Burnham, Hough, Karno, Escobar, & Telles, 1987; Karno, Jenkins, de la Selva, Santana, Telles, Lopez, Mintz, 1987; Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 1998) prompted Vega and Lopez (2001) to generate three interrelated conclusions regarding Latinos and mental health. The first was that Latinos had lower rates of psychiatric disorders as an overall population compared to Whites or African

Within Latino families, stresses often occur when children develop into adolescents, learn English, and become part of U.S. peer cultures.

A number of researchers

have documented that health problems, including substance abuse, depression, and anxiety disorders, are higher for Latinos with long-term settlement in this country.

Americans, which was thought to be linked to low rates of such disorders among immigrants (Vega & Lopez, 2001). It was also concluded that rates of disorders may increase over time as immigrants settle in this country, especially when they arrive as children (Vega & Lopez, 2001). The literature also suggested that Latinos with psychiatric disorders were “less likely to receive any type of care for their mental health problems when compared to non-Latinos” (Vega & Lopez, 2001, p. 191; see also Hough, Landsverk, Karno, Burnham, Timbers, Escobar, & Regier, 1987; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999; Wells, Hough, Golding, Burnham, & Karno, 1987).

According to the supplement to the Surgeon General’s Report on Mental Health (U.S. Department of Health and Human Services [U.S. DHHS], 2001), Latinos as a population are in great need of mental health services. These needs often vary among Latino groups, however, because of historical context and/or other factors, including state policies and procedures, and local implementation processes, which may ultimately inhibit access to services (Carrillo, 1990; Suarez-Orozco, 1989; U.S. DHHS, 2001; Vega & Lopez, 2001). For instance, individuals from certain countries in Central and South America that have experienced long-standing violence or repression may develop a series of disorders related to trauma (Weiss, Goebel, Page, Wilson, & Warda, 1999). The migration process itself can cause a number of stressors manifested throughout the continuum of adaptation and acculturation to this country (Falicov, 1998; Leon & Dziegielewski, 1999). Some of these stressors include the process of uprooting one’s family, leaving behind an extended family support system, the uncertainty of the journey itself, and/or the lack of knowledge regarding the various social systems immigrants encounter after their arrival in this country (Falicov, 1998). Such experiences can often lead to an increase in symptoms or mental health disorders, especially among individuals who find themselves with limited or no social supports upon settlement in this country. In addition, a number of researchers have documented that health problems, including substance abuse, depression, and anxiety disorders, are higher for Latinos with long-term settlement in this country (Ortega, Rosenheck, Alegria, & Desai, 2000; Vega et al., 1998). High rates of poverty, low rates of education, lack of health insurance coverage, and higher rates of incarceration among Latinos in various parts of the country can also work to compound the need for mental health services.

Latino youth, in particular, are documented as having a significant number of mental health problems, and “in most cases, more problems than Whites” (U.S. DHHS, 2001, p. 135; see also Glover, Pumariega, Holzer, Wise, & Rodriguez, 1999; Vazsonyi & Flannery, 1997). This finding is especially pronounced with respect to depression and anxiety-related disorders among Latino youth born in this country (Roberts, Roberts, & Chen, 1997; Roberts & Sobhan, 1992). Although the suicide rate for Latinos was about 6% in 1997 (National Center for Health Statistics, 2001), a national study conducted with high school students found that Latino adolescents exhibited more suicidal ideation and made more suicide attempts than White and Black students (Centers for Disease Control and Prevention, 1998). Despite these data presented in the

Surgeon General's report, a number of studies indicate that Latino children and youth generally exhibit low rates of mental health service use (Alegría, Canino, Lai, Ramirez, Chavez, Rusch, & Shrout, 2004; Bui & Takeuchi, 1992; Chow, Jaffee, & Snowden, 2003). As Vega and Lopez (2001) noted, the research literature provides little information as to the rate of unmet need among Latino youth despite the fact that nearly half of the population is under 18 years of age. Another important limitation noted within the literature is the fact that most studies of mental health problems in Latino children have not used diagnostic instruments or impairment criteria to assess study participants and instead have relied upon indices and/or checklists, thereby limiting the accuracy of assessments made – especially with regard to unmet need (Bird, Canino, Rubio-Stipec, Gould, Ribera, Sesman, Woodbury, M., Huertas-Goldman, S., Pagan, A., Sanchez-Lacay, A., & Moscoso, M., 1988; Shaffer, Fisher, Dulcan, Davies, Piacentini, Schwab-Stone, Lahey, Bourdon, Jensen, Bird, Canino, & Regier, 1996; Shaffer, Gould, Brasic, Ambrosini, Bird, & Aluwahlia, 1983; Vega & Lopez, 2001).

Findings

Overview of Articles Reviewed

Overall, the research on Latino child and adolescent mental health has varied with regard to the geographic scope, type of sample, and type of data collected, as evidenced in the 29 articles in Table 3. Within the pool of articles, five presented findings from national surveys conducted with samples collected randomly from across the United States. Four of the national surveys were fielded in 1996-1998, including the 1990-1992 National Comorbidity Survey, the National Health Interview, the National Survey of American Families, and the Community Tracking Survey. An additional three national surveys utilized were fielded in 1997, including the 1994-1995 National Longitudinal Study of Adolescent Health, the National Ambulatory Medical Care Survey, and the National Hospital Ambulatory Medical Care Survey (Alegría, Canino, Rios, Vera, Caldron, Rusch, & Ortega, 2002; Kataoka, Zhang, & Wells, 2002; Kodjo & Auinger, 2004; Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002). In addition, one article analyzed data from a total of 13 community and national level studies conducted between 1992 and 1998 (Ringel & Sturm, 2001).

The majority of articles reviewed focused on a single community in the United States or Puerto Rico. Fourteen articles presented findings conducted with diverse Latino groups in various urban areas around the United States (Alvidrez, 1999; Chow et al., 2003; Flisher, Kramer, Grosser, Alegría, Bird, Bourdon, Goodman, Greenwald, Horwitz, Moore, Narrow, & Hoven, , 1997; Gamst, Dana, Der-Karabetian, & Kramer, 2004; Hough, Hazen, Soriano, Wood, McCabe, & Yeh, 2002; Manoleas, Organista, Negron-Velasquez, & McCormick, 2000; McCabe, Yeh, Hough, Landsverk, Hurlburt, Culver, & Reynolds, 1999; McKay, Pennington, Lynn, & McCadam, 2001; McKay, Stoewe, McCadam, & Gonzales, 1998; Szalacha, Erkut, Garcia Coll, Alarcon, Fields, & Ceder, 2003; Takeuchi, Sue, & Yeh, 1995; Weiss, Goebel, Page, Wilson, & Warda,

Most studies of mental health problems in Latino children have not used diagnostic instruments or impairment criteria to assess study participants.

Table 3
Summary of Literature Review Articles: Latino

Citation	Sample			Issues Addressed	Domain
	Participants	Location	Age		
Alegría et al. (2004)	L, PR	Puerto Rico	4-17; Child & Caregiver pairs	Caregiver Recognition/ Interpretation/Beliefs; Help Seeking; Predictors of Use; Type of Service; Unmet Need; Utilization Rates	Availability Utilization
Alegría et al. (2002)	N =8,098; English Speaking Only (987 AA, 695 L, 6,026 W)	U.S.	15-54	SES; Service Types; Socio-Geographic Location	Availability Utilization
Alvidrez (1999)	N=187 (AA, L, & W)	Urban (Not identified)	Women	Attitudes Towards Mental Illness; Use of Mental Health Services	Utilization
Canino et al. (2002)	N =146 (PR, Spanish-speaking)	Puerto Rico	4-17; Children & Parents	Use of Mental Health Services; Outpatient Mental Health Services; School Services	Utilization
Chow et al. (2003)	N =78,085 (23,683 AA, 1,275 API, 19,849 L, 33,278 W)	NYC, NY; Urban	All Ages	High & Low Poverty Areas; Socio-Geographic Location	Utilization
Flisher et al. (1997)	N =1,285 Pairs (190 AA, 361 L, 71 O, 663 W)	CT, GA, NY, & Puerto Rico	Children & Parent Pairs	Correlates of Unmet Need; Personal & Familial Perceptions	Access
Gamst et al. (2004)	N =1,946 (426 AA, 851L, 669 W)	Eastern LA County, CA; Public, Outpatient MHS	6-18	Ethnic Match, Treatment Outcomes	Availability
Hough et al. (2002)	N=1,164; Random sample	San Diego County, CA; 5 public sectors of care	12-18; Adolescents	Prevalence of Mental Disorders; Use of Mental Health Services	Utilization
Hurlburt et al. (2004)	N =2,823 (899 AA, 487 L, 226 O, 1,208 W)	97 U.S. Counties; Specialty MHS	2-14	Interagency Linkages; Service Types	Access Availability Utilization
Jerrell (1998)	N =4656 (AA, API, L, W)	CA; Public MHS	Children & Adolescents	Ethnic Match	Availability
Kataoka et al. (2002)	Three national data sets from 1996-1998	United States	3-17; Children & Adolescents	Ethnic Disparities; Insurance Status; Unmet Need; Use of Mental Health Services	Utilization
Kodjo et al. (2004)	N =3,963 (15% AA, 12% L, 67% W)	80 Urban & Rural High Schools; U.S.	11-21; Grades 7-12	Access Point; Barriers & Predictors of Use	Access
Lasser et al. (2002)	73% AA, 11% L, >1% O, 15% W	U.S.	0-65+	Geographic Location; Service Types	Utilization
Manoleas et al. (2000)	N=65; L Convenience Sample	San Francisco Bay Area, CA	Clinicians & clients	Characteristics of Clinicians; Competence; Definitions of Cultural; Ethnic Match	Availability

Citation	Sample			Issues Addressed	Domain
	Participants	Location	Age		
Maynard et al. (1997)	N=32,452 (1,531 AA, 900 API, 2,167 L, 1,011 NA, 26,843 W)	WA; Public, Outpatient MHS	All Ages	Intensity & Types of Services	Access Availability Utilization
McCabe et al. (1999)	N=11,148 (2,539 AA, 546 API, 3,421 L, 4,642W)	San Diego County, CA; 5 Public Care Sectors	0-18	Service Types	Availability Utilization
McKay et al. (2001)	Study I: 405 (73% AA, 11% L, >1% O, 15% W); Study II: 100 (66% AA, 23% L, 4% O, 10% W)	Urban (Not identified)	3-17	Correlates of Initial & Ongoing Use	Utilization
McKay et al. (1998)	N =109 (≈75% AA, 12% L, ≈13% W)	Inner City Child MH Agency; Low-Income; Urban	1-14	Engagement Strategies	Access
McMiller et al. (1996)	N =192 (18% AA, 20% L, 63% W)	Southern CA; CMH Outpatient MHS	7-17; Children & Families	Help Seeking; Linkages with Other Supports; Pathways to Care	Access Availability
Pumariega et al. (1998)	N =2,405 (97 AA, 1,696 L, 527 W)	Coastal SE TX & Lower Rio Grande Valley; Outpatient MHS	Grades 7-12	Utilization Rates	Utilization
Ringel et al. (2001)	AA, L	U.S.	1-17	Unmet Need	Utilization
Sturm et al. (2003)	N=45,247 (6,371 AA, 6,022 L, 1,614 O, 31,240 W)	AL, CA, CO, FL, MA, MI, MN, MS, NJ, NY, TX, WA, WI	6-17	Geographic Location; Unmet Need	Utilization
Szalacha et al. (2003)	L, PR; two studies	Greater Boston, MA; Urban; Low SES	7-9; Children; 13-14; Adolescents	Acculturation; Internalization of Negative Feedback (Patient); Perceived Discrimination	Characteristics of the Population
Weiss et al. (1998)	L Only	Urban (Not identified)	2-3; Children	Acculturation; Behavioral & Emotional Problems; Poverty	Characteristics of the Population
Wu et al. (2001)	N =206 (71 AA, 38 L, 15 O, 82 W)	Westchester County, NY	9-17	Diagnosis	Utilization
Wu et al. (1999)	N =1,285 Pairs (AA, L, O, W)	CT, GA, NY, Puerto Rico	9-17; Children & Parent Pairs	Diagnosis	Utilization
Yeh et al. (2003)	N =1,338 (270 AA, 109 API, 372 L, 587 W)	San Diego, CA; Urban; Public, Outpatient MHS	6-17; Children & Parents	Barriers; Unmet Need	Access
Yeh et al. (2002)	N =3,962 AA, API, L	San Diego, CA; Urban; Outpatient MHS	0-17	Diagnosis; Referral Source	Access Utilization
Yeh, Eastman, et al. (1994)	N =4,616 (1,219 AA, 903 API, 1,498 L, 996 W)	LA County, CA; Public, Outpatient MHS	6-17	Ethnic & Language Match	Availability

Note. AA=African American, API=Asian/Pacific Islander, L=Latino, NA=Native American, O=Other, PR=Puerto Rican, W=White

A majority of the articles reviewed failed to identify specific linguistic or ethnic characteristics of the Latino population(s) studied.

1999; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003; Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, & Landsverk, 2002). In addition, four articles analyzed state level data or relied on community-based data within particular states (Maynard, Ehreth, Cox, Peterson, & McGann, 1997; McMiller & Weisz, 1996; Pumariega, Glover, Holzer, & Nguyen, 1998; Sturm, Ringel, & Andreyeva, 2003; Wu, Hoven, Cohen, Liu, Moore, Tiet, Okezie, Wicks, & Bird, 2001). Finally, a total of four articles presented data collected from populations in Puerto Rico (Alegría et al., 2004; Canino, Shrout, Alegría, Rubio-Stipec, Chavez, Riber, Bravo, Bauermeister, Fabregas, Horwitz, & Martinez-Taboas, 2002; Flisher et al., 1997; Wu, Hoven, Bird, Moore, Cohen, Alegría, Dulcan, Goodman, Horwitz, Lichtman, Narrow, Rae, Regier, & Ruper, 1999).

The articles reviewed for this monograph presented geographic variability in the Latino populations studied, but the demographic data provided by the articles was limited. A majority of the articles that were reviewed failed to identify specific linguistic or ethnic characteristics of the populations studied. Large-scale studies, in particular, often failed to identify the countries of origin of the Latino sample and/or the degree to which English was spoken. Several studies reviewed for this chapter did not specify the English-speaking ability of respondents and/or whether measures and instruments had been adequately tested for use with Spanish monolingual or limited English speaking populations (Alegría et al., 2004 ; Alegría et al., 2002 ; Wu et al., 1999). In their study on unmet need, Flisher et al. (1997) did not specify differences in population characteristics between Latino respondents from U.S. study sites (Atlanta, Georgia, New Haven, Connecticut, and Westchester County, New York) and those from a San Juan, Puerto Rico site. As a result, interpretation of findings was difficult because Latinos comprised significant proportions within each of the study sites in the United States and these communities may have had more diverse Latino populations than the Puerto Rican site. Such detailed information on specific study samples is important to include in research to know the extent to which findings generalize to other Latino populations.

The majority of articles reviewed focused on unmet need and utilization rates among Latino children and adolescents. This finding is not altogether surprising given the attention that has been given to the underrepresentation of Latinos within mental health services, as noted in the Supplement to the Surgeon General's Report (U.S. DHHS, 1999). A number of articles also focused on issues related to access, noting the importance of extended family in the process of help-seeking and the need for increased outreach and engagement to these communities to facilitate access to specialty services and resources (Alegría et al., 2004; Alvidrez, 1999; Flisher et al., 1997; McKay, et al., 2001; McKay, et al., 1998; McMiller & Weisz, 1996; Yeh et al., 2002). Few articles addressed availability of services, most focused primarily on ethnic match between Latino families and providers. While ethnic matching has been identified as an important component to providing culturally responsive services (U.S. DHHS, 1999), the lack of Latino professionals in behavioral health fields presents a challenge in this area. In addition, for many Latinos availability of services may be limited by area of residence, suggesting that underutilization of specialty services might not be directly related to ethnicity and should be examined in conjunction with a number of other variables, especially poverty status (Alegría et al., 2002; Pumariega et al., 1998).

Cultural and Linguistic Characteristics of the Population

The cultural/linguistic population characteristics shown in the conceptual model interact with an organization's/system's combined policies, structures, and processes (Hernandez & Nesman, 2006). The area of compatibility represents the potential for improving outcomes by reducing mental health disparities. This section will discuss studies that examine the highlighted section of the diagram and provide pointers for enhancing compatibility.

Characteristics associated with the Latino population have been found to affect access to services and the utilization of these services. Parents' beliefs about their child's disability, awareness of their child's educational and therapeutic needs, and understanding the relevance of the range in services and supports that are available to address their child's issues are important characteristics that affect whether parents seek services for their children (Bailey, Skinner, Rodriguez, Gut, & Correa, 1999). For instance, Latino families are more likely to consult with family and other natural supports instead of mental health professionals or agencies (Briones, Chalfant, Roberts, Aguirre-Hauchbaum, & Farr, 1990; Hoberman, 1992; McMiller & Weisz, 1996). Moreover, Latino families often fear seeking mental health assistance or advocating for other services because of fear of punitive consequences to themselves and other family members (Douglas-Hall & Koball, 2004; Wirth & Dollar, 2004). Much of this fear stems from immigration experiences, experiences with authorities in their countries of origin, or unfamiliarity with U.S. schools and social services (Suarez-Orozco, 1989). In a study conducted with immigrant Latino parents of preschool aged children, Weiss et al. (1999) found that emotional problems were more likely among the children of immigrant parents who relied on internal coping mechanisms to deal with the stress of their migration experiences. The authors further found that these variables, as well as cultural heritage (e.g., a home country's history of violence or repression) and family functioning were more predictive of a child's emotional problems than were variables such as the family's economic conditions or a parent's ethnic identity (Weiss et al., 1999). The authors recommend additional research with larger samples of Latinos to test their findings and suggest development of "culturally sensitive interventions... which more actively involve the community and social networks" (Weiss et al., 1999, p. 299).

In an attempt to examine Latino youth and perceptions related to their mental health, Szalacha et al. (2003) conducted two studies with children and adolescents of Puerto Rican descent in the greater Boston area to determine the degree to which perceived discrimination resulted in negative mental health indicators. The studies attempted to ascertain the relationship between perceptions of discrimination and distress related to prejudicial, racist or discriminatory events and mental health indicators, especially among adolescents (Szalacha et al., 2003). Children and adolescents who reported having been victims of discrimination identified themselves explicitly as Puerto Rican (either solely or in combination with Hispanic and/or American), and they attributed their discriminatory experiences to their ethnicity. Results of both studies indicated that perceived discrimination produced negative mental health results, although children ages 7-9 were far less likely than adolescents



to report perceived discrimination (Szalacha et al., 2003). By contrast, nearly half of the adolescents reported perceiving discrimination directed against them in at least one situation and/or worried about being discriminated against (Szalacha et al., 2003). While the authors found that perceived discrimination and/or anxiety over possible discrimination were risk factors associated with poor mental health, the results did not establish causality because of the possibility that certain indicators for mental illness in children could predispose them to perceive discrimination more frequently or readily or even increase their exposure to discrimination (Szalacha et al., 2003). Interestingly, the authors failed to explicitly discuss the racial identity of the children and youth sampled and how they reported their race for the purposes of the study.

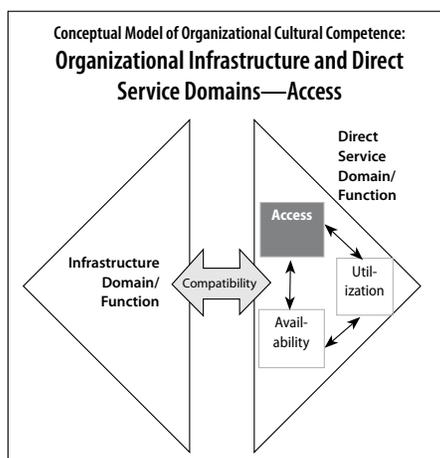
Access to Services

Access interacts with availability and utilization to form the direct service domain. A culturally competent organization seeks compatibility between the direct service functions and those of the organizational infrastructure to form a combined set of policies, structures, and processes that will enhance services for culturally and linguistically diverse children and families. This section will discuss studies that examine the highlighted section of the model and provide pointers for enhancing compatibility.

It is important to consider the diverse nature of the Latino population when examining the factors that facilitate or hinder access to mental health services. In view of the direct service and organizational mechanisms that facilitate a person's ability to enter into, navigate, and exit appropriate services and supports, service providers must remember that the Latino population includes a high proportion of immigrants with varying levels of acculturation, language preferences, beliefs about mental health and illness, and help-seeking behaviors. Furthermore, Latinos tend to seek advice and information related to their children's well-being from trusted family and community contacts (Briones et al., 1990; Hoberman, 1992). Such factors may increase barriers to service access unless service providers adapt their practices to engage the family and community upon which Latino families rely to increase treatment compliance program/service utilization or risk alienating family members. Castro, Cota, and Vega (1999) identify community outreach as a critical element in engaging disadvantaged Latino communities within services or programs.

Barriers to Care

In a study on unmet need, parents were asked to identify factors that might prevent them from seeking needed mental health services for their children. The top four access barriers identified were: 1) belief that the child/adolescent would want to handle problems on his/her own; 2) services would be too expensive; 3) concern about losing custody of the child/adolescent or hospitalization; and 4) health insurance would not cover services or treatments (Flisher et al., 1997). Flisher et al. (1997) concluded that parental beliefs about barriers affect whether children reach needed services. McKay et al. (2001) found that positive parental efficacy and attitudes toward mental health services are significantly associated



with a child's attendance at an intake appointment. They stress the importance of helping parents identify these and other attitudes during their interaction with the child mental health system. They recommend further research to document specific parent perceptions that may affect access to services, including "perceptions of causes and solutions of child difficulties, past experiences with mental health services, and beliefs about professional mental health providers" (McKay et al., 2001, p. 480).

In a more recent study focused specifically on parental perceptions of barriers to mental health services for children, Yeh et al. (2003) found no significant relationship between rates of unmet need and perceptions of barriers to services by parents of these youth. In a particularly interesting finding, all three ethnic groups sampled (African American, Latino, and Asian/Pacific Islander), reported encountering fewer barriers than did non-Hispanic Whites, with few exceptions. Parents of Latino children were more likely to report experiencing barriers related to language even when the authors controlled for the level of acculturation among respondents (Yeh et al., 2003). Overall, Latino parents reported fewer barriers than did Whites and were less likely to report accessibility barriers (defined as "items delineating practical problems related to service use; e.g., a lack of knowledge of where to go for services") (Yeh et al., 2003, p. 69). Given these unexpected results, Yeh et al. (2003) suggested the possibility that perceived barriers might reflect cultural and other characteristics of Latinos and other populations with similar findings. For instance, immigrants who arrive from countries where mental health services are scarce or unavailable may perceive the services that are available in this country as being superlative or may not recognize problems with services even where problems exist. The authors also noted that some Latino cultures may inhibit individuals from voicing complaints about service providers, who are seen as being respected authorities, especially when families were expected to assess the level of services received or if they disagreed with a diagnosis or treatment (Yeh et al., 2003). They suggested that future research take cultural values into account when examining parental perceptions of mental health service barriers.

Parents' Help-seeking Behavior

McMiller and Weisz (1996) examined parents' help-seeking behaviors prior to their children's admission for outpatient treatment in one of seven community health clinics in central and southern California. They found ethnicity to be significantly related to parents' help-seeking behaviors – Latino parents were more likely to contact family or community members versus professionals as a first step in seeking help for their child's mental health issues (McMiller & Weisz, 1996). Moreover, decision-making related to a child's health is most often a collective or family endeavor rather than an individual judgment (McMiller & Weisz, 1996). Similarly, Yeh et al. (2002) found that Latino parents were more likely to have been referred for mental health services by family members than from within the mental health service system. They attributed this finding to the availability of ethnic-specific agencies in the study's target community, suggesting that family and friends may recommend services when ethnic-specific agencies or providers are available.

Latino parents are more likely to contact family and/or community members versus professionals as a first step in seeking help for their child's mental health issues.

Low level of contact

between Latino families and professional mental health agencies and providers suggests a need to expand outreach to Latino communities.

Researchers examining parental help-seeking behaviors also found a significant relationship between the perceived severity of their children's mental health problems and parents' help-seeking behavior. McMiller and Weisz (1996) found that those who perceived their child to have more severe problems were more likely to seek professional help. They speculated that while Whites may be more familiar with professionals and agency contacts, minority parents may wait to make such contacts until the level of severity of their children's problems is much higher. Yeh et al. (2002) documented similar findings with regard to the severity of anxiety, adjustment, and/or psychotic disorders in Latino youth who were part of their study sample. They also suggested that Latino parents may be waiting to seek professional mental health services until problems become more severe. In a more recent study focused specifically on the help-seeking behaviors of parents in Puerto Rico, Algeria et al. (2004) suggested that high rates of unmet need may be explained by uncertainty on the part of caregivers "interpretation of children's psychiatric symptoms" (p. 452). According to their study prediction model, parents would be more likely to seek care if they were aware of "the impact of symptoms on [their] child's functioning" (Alegría et al., 2004, p. 452). They recommended additional research to further elucidate how caregiver characteristics might affect help-seeking behaviors.

Outreach and Engagement

Several authors noted that the low level of contact between Latino families and professional mental health agencies and providers suggests a need to expand outreach to Latino communities (Alvidrez, 1999; Flisher et al., 1997; McMiller & Weisz, 1996). Such efforts should include outreach to specific community leaders and Latino families directly, rather than notifying other professionals and agencies about their services (McMiller & Weisz, 1996). In their recommendations, McMiller and Weisz (1996) suggested that such efforts should be evaluated through the use of periodic surveys to assess whether outreach efforts reach the intended populations and whether pathways into care or relationships with formal service providers are enhanced.

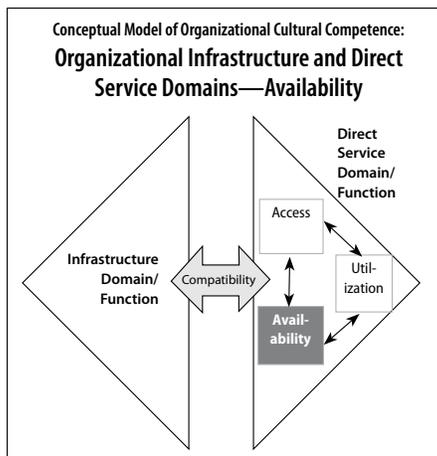
Outreach coupled with education to parents about mental illness and available services/treatments has been recommended fairly consistently by researchers interested in reducing high rates of unmet need among minorities. Flisher et al. (1997) stressed the importance of "involving the families in the assessment and intervention processes immediately after the initial contact with mental health services" (p. 1153). They recommended increasing parental knowledge about mental health services to increase service use but did not provide specific examples of how to do so. Alegría et al. (2004) recommended implementation of a public health education campaign to help caregivers "understand the link between impairment and the child's need for mental health care" (p. 452). Although Latino families have been found to seek initial help from informal or natural supports when confronted with mental illness in their children, researchers have found that they will seek formal services when symptoms are more pronounced or severe. Increasing parent education through targeted outreach efforts can help parents more effectively identify symptoms that require professional attention and can help Latino families reach

needed services more effectively. Alvidrez (1999) further recommends targeting education to Latina adolescents and young women to “inform them about the causes, identification, and treatment of psychiatric disorders...focused on external or observable causes and symptoms...and the observable changes in these symptoms that could result from seeking professional treatment” (p. 528).

In an effort to study specific interventions aimed at reducing barriers to mental health services among urban children, McKay et al. (1998) evaluated a combined telephone-engagement and first-interview intervention used within an inner city child mental health agency to increase and maintain patient responsiveness. Although they did not identify findings specific to Latinos, they did find that a combined engagement intervention resulted in a 25% increase in continued service use over families who only received a telephone-engagement intervention. They also highlighted an alarming study result—without ongoing engagement, mental health providers might lose up to 56% of cases between an initial telephone call requesting services and an initial intake appointment (McKay et al., 1998). The authors further emphasized the importance of helping clients to identify and address existing barriers to continued treatment throughout the client engagement process. These findings appear to corroborate those of McMiller and Weisz (1996) who recommended that mental health professionals may need to take more time with minority families, including Latinos, to allay fears or concerns and earn their trust during the initial contact with families. They suggested that minority parents “enter the professional agency setting of the mental health clinic with greater reluctance, with a different level of enthusiasm, and with different expectations and concerns than do many Caucasian families” (McMiller & Weisz, 1996, p. 1092). As a result, providers might have to take more time during the initial intake phase to reassure families and work to gain their trust before treatment can begin.

In a more recent study examining the correlates between mental health service use among urban children and environmental factors, McKay et al. (2001) noted that targeted engagement practices have been found to increase access to services for children and their families. In particular, they recommended that providers incorporate the following practices to help alleviate access barriers: target intake procedures and interventions to specific barriers; implement training and supervision with an emphasis on engagement at initial intake; and obtain consumer input to develop innovative service delivery options, outreach efforts, and alternative service locations. The authors also recommended additional research with parents to more clearly identify the factors that hinder them from bringing their children to needed services. In particular, they discussed the finding that parents who reported having difficulty disciplining their children were significantly less likely to attend an initial intake or continue services for their child (McKay et al., 2001).

Mental health professionals may need to take more time with minority families, including Latinos, to allay fears or concerns and earn their trust during the initial contact with families.



Availability of Services

Availability of services is the second function within the direct service domain. This section will discuss studies that examine the highlighted section of the model and provide pointers for enhancing compatibility between the direct service functions and the organizational infrastructure.

One important aspect associated with mental health disparities relates to what individuals think about the way services are delivered and the type of services that are offered. That is, service utilization is affected by whether services match families' perception of needs and whether they are delivered in a manner that is perceived by the family to be caring and competent. Satisfaction with services has been associated with effective service delivery methods such as culturally/linguistically appropriate assessments, referrals to services, and the availability of bicultural and bilingual mental health services and supports (Peifer, Hu, & Vega, 2000). However, no major studies exist with regard to the availability of culturally matched mental health services for Latinos although cultural influences in mental health, illness, and services are important considerations in addressing disparities for Latino children with SED and their families (U.S. DHHS, 2001). The research available on ethnic matching in mental health services points to an overall lack of Latino/Spanish-speaking providers nationwide with less than 29 Latino mental health professionals for every 100,000 Latinos in the U.S. population compared to 173 per 100,000 for Whites (Center for Mental Health Services [CMHS], 2000). Yeh et al. (2002) recommended emphasizing ethnic-specific providers in outreach to Latino families about available mental health services.

Ethnic-Specific Services

Ethnicity of the provider is linked to the kinds of strategies or approaches that are effective for working with Latino populations. Manoleas et al. (2000) focused on Latino mental health providers to determine characteristics associated with Latino mental health providers and their work with patients. They found that Latino mental health clinicians used different approaches with their Latino clients versus their non-Latino clients and that these approaches were “guided by cultural factors” (Manoleas et al., 2000, p. 392). Based on results from focus groups and surveys, Latino clinicians reported being more likely to follow up on missed appointments with phone calls to the client and/or other family members and friends and did not close cases without first speaking to clients, highlighting the importance of conducting outreach with Latino populations. Latino clinicians also reported being more apt to self-disclose to their Latino clients versus their non-Latino clients (Manoleas et al., 2000). The authors characterized such differences in behavior with their patients as an example of implementation of personalism (personalismo) and trust (confianza), concepts which have been identified as being important among Latino populations (Manoleas et al., 2000). Conversely, most of the respondents indicated that they preferred to work with clients in conventional time blocks of one hour and “at frequencies mutually negotiated with clients,” suggesting that Latino therapists implemented “universal clinical standards” with all patients and that Latino clients may be successfully acculturated to respond to such standards (Manoleas et al., 2000, p. 392). Although

Manoleas et al. (2000) cautioned against generalizing study results beyond their convenience sample of Latino therapists (mostly social workers) in the San Francisco Bay area, they noted that their findings provided a starting point from which program planners could develop “formats for framing culturally relevant treatment outcomes for Latinos” (p. 393) and to guide further research.

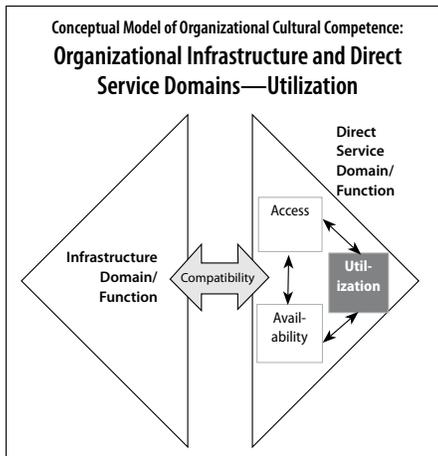
While the availability of ethnic-specific providers might increase service accessibility and utilization, age of the client and other family characteristics might influence service outcomes more than ethnicity of the provider. Jerrell (1998) found that ethnic match was positively associated with outpatient service use, although the study did not specify results by ethnic group. Two separate studies conducted in Los Angeles County found that ethnic matching of mental health service providers with children did not significantly influence treatment outcomes and/or visitation rates (Gamst et al., 2004; Yeh, Eastman, & Cheung, 1994). Ethnic matching does appear to have salience with regard to treatment outcomes in adolescents, however. In their study with children and adolescents receiving services at a public mental health center, Gamst et al. (2004) found that Latino adolescents (14 to 18 years) with mood disorders experienced improved clinical outcomes when compared to non-Hispanic White adolescents. Yeh et al. (1994) reported similar findings in an earlier study including Mexican American youth ages 6 to 17 years. While ethnic match was not a significant predictor of dropout nor attendance for children, adolescents who were matched by ethnicity and language were less likely to dropout from services and attended more service sessions overall (Yeh et al., 1994). Further, language was a significant predictor of dropout for Mexican American adolescents (Yeh et al., 1994). Gamst et al. (2004) suggested that children might not respond to ethnic matching as readily as adolescents because they did not yet have fully formed concepts related to ethnic identity. However, these findings did suggest that adolescents could benefit from receiving treatment from ethnically matched providers.

Geographic Availability of Services

Geographic location, in terms of resource availability, appears to be an important barrier to access that needs to be considered. Alegría et al. (2002) contend that studies of underutilization of mental health services must examine the combined effects of poverty, minority status, and geographic location because the effects of ethnicity did not fully account for low rates of use among minorities. They speculate that for poor Latinos, low rates of specialty care use might be caused by a lack of Medicaid accepting services in Latino neighborhoods compared to those of non-Latino Whites. In their comparison of utilization rates among adolescents in Texas, Pumariega et al. (1998), found a negative correlation of service utilization with residing in the lower Rio Grande Valley of Texas. They attributed this correlation to the relative lack of services available in the area as compared to the second study site in Galveston County.

Ethnic matching

appears to have salience with regard to treatment outcomes in Latino adolescents.



There is an ongoing need to find better ways to define utilization, elicit information about service use, and track user characteristics and patterns.

Utilization

Utilization is the final direct service function. This section will discuss studies that examine the highlighted section of the model and provide pointers for enhancing compatibility.

Low utilization rates of mental health services for Latinos have been reported for several decades, yet much remains to be explained regarding what these rates represent. Since the 1980s, studies have been reporting that Latinos were less likely to use mental health services than their White counterparts (Hough et al., 1987; U.S. DHHS, 2001; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999;). Findings also indicated that Latinos with mental disorders were more likely to use services of general health practitioners rather than specialty mental health services (U.S. DHHS, 2001). More general findings in the literature point to the need for better descriptions of specific characteristics of service users and types of services received. For example, researchers were surveyed to determine if they were including primarily Spanish-speaking families within research studies and/or accurately capturing data from Latinos (e.g., Alegría et al., 2004; Alegría et al., 2002; Wu et al., 1999). In addition, elicitation methods need to be examined to ensure that data were valid and reliable. A study conducted in Puerto Rico found that parents and children had limited reliability in reporting on the child's mental health service use even within a single year (Canino et al., 2002). Although a higher degree of reliability was found with regard to reporting use of more restrictive services such as residential treatment centers and hospitalization, both parents and children were often unable to distinguish between specific types of services used (i.e., school-based services versus other mental health professional services). The literature suggests there is an ongoing need to find better ways to define utilization, elicit information about service use, and track user characteristics and patterns to identify and reduce disparities in mental health services in the United States.

Unmet Need

Studies of children and adolescents with mental health need have reported high overall levels of unmet need for Latinos. Latino children involved in the social welfare system were found to be half as likely as non-Hispanic White children to receive mental health services despite identified need (Hurlbert et al., 2004). Flisher et al. (1997) used data derived from four community-based studies conducted in the United States and Puerto Rico to assess mental health service use among Latino and White children and adolescents. The study found that 17.1% of the sample had unmet mental health needs. Although the authors found that gender, age, and being Latino were not significantly associated with unmet need, variables associated with economic disadvantage were significant, including receiving public assistance, not having health insurance, and transportation problems. Lasser et al. (2002) also found unmet need for a variety of mental health services by Latinos compared to Whites. Latino patients received less mental health care in primary care settings and had fewer psychiatric visits than their White counterparts (Lasser et al., 2002). In addition, Latinos visited psychiatrists less than half as often and had significantly lower rates of psychoactive drug therapy than did Whites (Lasser et al., 2002). The authors also reported that Latinos

in outpatient care were younger and had higher rates of Medicaid coverage than their White counterparts (Lasser et al., 2002). They attributed the disparities in mental health utilization rates to “institutional racism,” which included differential rates of insurance coverage and access, a lack of transportation and minority and/or bilingual providers in minority neighborhoods, and time restrictions that “low-status-workers” face when seeking services, which in combination with other factors greatly impacted their mental health care (Lasser et al., 2002). These observations, in conjunction with findings from Flisher et al. (1997) suggest the importance of considering factors related to economic disadvantage that limit utilization of certain types of services.

Insurance status has been linked to unmet need for racially/ethnically diverse children and adolescents who need a mental health evaluation. Kataoka et al. (2002) examined three national data sets to study rates of use and unmet need by ethnicity and insurance status. Their study found that “most children and adolescents who need a mental health evaluation do not get any mental health care in a year, and this was more pronounced for Latinos and the uninsured” (Kataoka et al., 2002, p. 1552). Despite some study limitations regarding definitions of mental health “need” and levels of use or “met need,” they found that Latino children had higher rates of unmet need than White or African American children. The authors highlighted this particular finding by pointing out national estimates that indicate Latino children and adolescents exhibit higher rates of suicide ideation, depression and anxiety symptoms, and school dropout (Kataoka et al., 2002; U.S. DHHS, 2001). These findings did not significantly differ for children of parents born in the United States versus foreign-born parents (Kataoka et al., 2002). Based on their findings, they recommended addressing barriers to services encountered by Latinos, including the lack of bilingual/bicultural providers and financial constraints.

Research indicates that factors such as age, ethnicity, and possible overdependence on community services such as primary care and the educational system should be considered by providers. Ringel and Sturm (2001) examined national data on expenditures in children’s mental health and how these affected utilization rates. The authors found substantial variation in utilization rates by type of insurance coverage. Children with Medicaid coverage were found to be most likely to receive mental health services than were children with no insurance coverage (Ringel & Sturm, 2001). Latino children were found to have the lowest utilization rates and the highest level of unmet need, second only to the “other minorities” category (Ringel & Sturm, 2001). It was found that nearly 60% of funds were allocated for outpatient services and primary care physicians provided about one third of mental health care for children and adolescents (Ringel & Sturm, 2001). In addition, findings suggested that most mental health services were not covered by insurance and was most likely being provided within the educational system (Ringel & Sturm, 2001). Examination of expenditures also revealed that 60% of the funds spent on children’s mental health nationally went to adolescents, while only 6% were spent on pre-school aged children (Ringel & Sturm, 2001). These findings suggest the importance of examining trends in insurance coverage and spending to address disparities, and the need for tracking recipient characteristics such as age and ethnicity.

Insurance status has been linked to unmet need for racially/ethnically diverse children and adolescents who need a mental health evaluation.

State of residence affects use of mental health services more than sociodemographic variables, including race/ethnicity and income.

Differences in use of mental health services compared to level of need have also been documented across states of residence, where health care markets and policies that affect access vary considerably. Sturm et al. (2003) used data from the National Survey of America's Families (NSAF), focusing on a sample of children and adolescents in 13 states with diverse representation of geographic location, state size, demographics, and political traditions. The authors found that state of residence affects use of mental health services more than sociodemographic variables, including race/ethnicity and income (Sturm et al., 2003). Significant differences in service use and level of need were found across the states sampled in comparison to the national average (Sturm et al., 2003). Sociodemographic variables, especially income, played a larger role than expected, with high-income children more likely to receive services but less likely to exhibit substantial symptoms (Sturm et al., 2003). Perhaps more importantly, there was no apparent relationship between levels of service use and levels of need across states (Sturm et al., 2003). Overall, Latino children were significantly different from the national average with the highest rates of unmet need recorded, as well as the lowest rates of service use (Sturm et al., 2003). In a comparison between states it became evident that Latino children in some states had even higher unmet needs than indicated by the national rates. For instance, children in California, where there is a large Latino population, were three times more likely to have unmet need than children in Massachusetts. The authors suggested that such differences in unmet need have to do with the way in which state policies and "health care market characteristics" interact with sociodemographic characteristics of each state (Sturm et al., 2003). A strong recommendation is for additional research to identify the specific characteristics within states that drive these disparities.

Rates of Utilization

Studies focusing on utilization rates indicate that race/ethnicity affects service use patterns in combination with socioeconomic status and that both should be taken into consideration in service delivery. Three studies examined public sector utilization rates among diverse children and adolescents in the states of California and Washington. One study conducted in San Diego County examined service use patterns across five public sectors of care for children and adolescents in four racial/ethnic groups (African American, Asian/Pacific Islander, Caucasian, and Latino) (McCabe et al., 1999). Data were culled from three sources: 1996 census estimates, 1996 200% Poverty Census data, and the 1997 San Diego County, California school enrollment data. The study results showed differences in service use patterns by both race/ethnicity and socioeconomic status. Latinos were underrepresented across all five of the service sectors (alcohol/drug treatment, child welfare, juvenile justice, mental health, and school SED services) (McCabe et al., 1999). Latino underrepresentation in school SED services was particularly striking – utilization rates in this sector were recorded at 31% and 44% of expected rates based on the 200% Poverty Census and School Enrollment data, respectively (McCabe et al., 1999). The authors called for additional research focused on prevalence rates, cultural thresholds for symptomatology, the use of alternative mental health services, and different beliefs about mental health/mental illness (McCabe et al., 1999). Studies

including these factors would improve understanding of the ways in which culture impacts utilization of public sector services and could lead to more appropriate adaptations within specific community contexts.

Hough et al., (2002) examined Latino adolescents with psychiatric disorders who enter specialty mental health services in San Diego County. This study focused on prevalence and utilization rates among Latino and White adolescents who were receiving public sector care. Ages ranged from 12 to 18, and the majority of Latinos were of Mexican descent (85%) (Hough et al., 2002). Mental disorders were assessed with the Diagnostic Interview Schedule for Children, and use of mental health services was assessed with the Service Assessment for Children and Adolescents (SACA). The authors found that rates of disruptive disorders were “very high” among Latino adolescents in public sectors of care, but White adolescents were more than twice as likely to receive a disruptive disorder diagnosis (Hough et al., 2002). Further, although more than half of the Latino sample received specialty mental health services, those with psychiatric disorders entered these services at a later age and had made significantly fewer visits in the previous year (Hough et al., 2002). Latino youths were significantly less likely than White youths to use specialty mental health services independent of diagnosis, gender, age, and the service sector from which they were selected (Hough et al., 2002). The authors cited the lack of a Spanish-language acculturation measure and a Spanish-language diagnostic assessment instrument as weaknesses in the study because they did not allow for measurement of acculturation in adolescents and effectively excluded Spanish monolingual respondents (Hough et al., 2002). They suggested that the inclusion of Spanish monolingual respondents would have resulted in even lower utilization rates than those reported (Hough et al., 2002). As suggested by the findings, reasons for low utilization rates, defined as fewer visits and later age of entry, are another area requiring additional research.

Maynard et al. (1997) examined differences in the utilization of public mental health services by five racial/ethnic groups in Washington State. Patients in this study were enrolled in the state’s mental health management information system, which contained detailed information about patient characteristics and service utilization. It was found that Latino participants were considerably younger than their White counterparts (mean age was 25 years), with 45% younger than 18 years (Maynard et al., 1997). In addition, nearly 70% of the Latino sample fell below the federal poverty guidelines and had no regular source of income (Maynard et al., 1997). Overall, Latinos were more likely to use individual therapy and were less likely to use group therapy, medication management, day treatment, and crisis services than Whites at similar income levels (Maynard et al., 1997). Utilization rates for family therapy were comparable to those of Whites (Maynard et al., 1997). Reasons for differential use of services were not documented, suggesting the need for more research to better understand the key factors involved in this process.

McKay et al. (2001) attempted to explain differential service use by identifying contributing factors found within the family. McKay et al. (2001) examined data from two studies to identify correlates of service utilization among children

Latino youths were significantly less likely than White youths to use specialty mental health services independent of diagnosis, gender, age, and the service sector from which they were selected.

Poverty status and geographic location had a greater impact on utilization rates than did barriers related to language or culture (Alegría et al., 2002).

and adolescents at an urban child mental health center. Latinos comprised 11% of children and 23% of adolescents in the study samples. The first study focused on child factors that might affect ongoing service use and found no significant difference between race/ethnicity and initial or ongoing service use (McKay et al., 2001). The second study explored the impact of parent and family factors on ongoing service use of children. In this instance, the authors found parental attitudes about mental health and discipline to be significantly related to initial service attendance (McKay et al., 2001). Overall, the study results indicated that levels of family stress and social support affect service use rates – higher rates of family stress resulted in lower attendance, while the presence of social supports increased attendance and use of services (McKay et al., 2001). Based on these findings, the authors recommended the development of interventions that target the entire family to increase utilization of mental health services among children and adolescents (McKay et al., 2001). Additional research on specific factors that affect the utilization process may assist in developing specific strategies to increase use by racially/ethnically diverse children and/or adolescents.

Geographic Variation in Utilization

Research also points to the impact of geographic location and associated community characteristics on utilization of services. Three studies focused specifically on determining geographic variation in mental health utilization rates among Latinos and other ethnic minority populations. Each study defined the geographic area of focus differently, ranging from variations at the national level to differences within a particular city. Alegría et al. (2002) found that poverty status and geographic location had a greater impact on utilization rates than did barriers related to language or culture. They found significant differences between the African Americans, Latinos, and Whites related to demographic data, psychiatric morbidity, and area of the country (Alegría et al., 2002). The Latino population sampled was younger, less likely to have been married, less likely to have health insurance coverage, and more likely to live in the South or the West (Alegría et al., 2002). Latinos were also more likely to have had two or more previous-year psychiatric disorders than Whites (Alegría et al., 2002). No significant difference was found in the rate of use for mental health, general health, or human services for respondents who experienced psychiatric disorders within the previous year (Alegría et al., 2002). However, Latinos reported using fewer specialty services than did Whites (Alegría et al., 2002). Further, odds ratios calculated to measure use of any specialty care by poor respondents were significantly lower for Latinos than for Whites, and poor respondents living in the South were significantly less likely to receive specialty care than those in the Midwest (Alegría et al., 2002).

In a second study, geographic location and demographic/community characteristics were found to impact level of use in two regions of Texas (Pumariega et al., 1998). Mental health service utilization rates among secondary school students were compared between two communities that differed in mental health service availability (Pumariega et al., 1998). The study sample included students from the Rio Grande Valley, one of the few areas in the nation where Latinos constitute the majority population, and Galveston County. Findings across com-

munities included significantly lower numbers of mental health visits reported by Latino respondents compared to White respondents and higher numbers of visits by Latino females than males (Pumariega et al., 1998). Other factors associated with greater use were level of mother's education (indicating increased socioeconomic status) and increased symptomatology (Pumariega et al., 1998). Latino youth in the border community of Lower Rio Grande Valley reported significantly fewer visits than did those in Galveston County, a difference which was attributed to the level of available services (Pumariega et al., 1998). In both communities, children without a father in the home were more likely to use mental health services, but it was not clear as to whether this indicated greater mental health need, greater perception of need, or increased need for family supports (Pumariega et al., 1998). In addition, immigrant Latino youth and those who identified themselves as speaking English poorly had higher rates of service utilization, which could reflect differences in service availability in the two regions, or the differential influence of stigma within these two Latino communities (Pumariega et al., 1998). The authors recommended that similar studies be conducted in different settings to better understand the ways in which community context affects service utilization (Pumariega et al., 1998).

Chow et al. (2003) examined different service use patterns for Latino youths in low poverty and high poverty areas in New York City. Mental health service use patterns were compared for low-poverty areas (LPAs) in which less than 20% of households fell below the poverty level, and high-poverty areas (HPAs) in which 20% or more households were below the poverty level. Latinos using the mental health system tended to be younger than Whites and had higher utilization rates than Whites in both HPAs and LPAs (Chow et al., 2003). Latinos were also more likely to be enrolled in Medicaid than White children in both poverty areas (Chow et al., 2003). Differences between geographic locations were seen in the greater use of emergency services for mental health problems by Latinos in LPAs, and lower use of inpatient services in HPAs (Chow et al., 2003). Latinos were also significantly more likely to be referred for services by the criminal justice system in LPAs, compared to negligible differences by race/ethnicity for criminal justice involvement in HPAs (Chow et al., 2003). The authors noted that disparities in service use were more visible in LPAs, where minorities comprise a larger proportion of the community and negative reactions to mental illness and community-based care may have a greater impact on help-seeking (Chow et al., 2003; see Segal, Baumohl, & Moyles, 1980). Differences in patterns of service use by Latino youths in these communities point to the importance of understanding not only demographic factors but also system level factors that impact diverse communities.

Utilization Rates by Diagnosis/Symptoms

Utilization rates have also been linked to differences in the rate of identification and treatment for Latino children compared to other groups, as well as differences within the Latino population. One study examined the relationship between depressive and disruptive disorders and mental health service utilization among children and adolescents (aged 9 to 17 years) in selected areas within

Differences in patterns of services use by Latino youths living in low- and high-poverty areas reflects the importance of understanding the system level factors that influence service use.

Sixty-five percent of children identified as having impairments did not receive any mental health services, even though 61.4% of these children had a psychiatric diagnosis (Alegría et al., 2004).

Puerto Rico and the states of Connecticut, Georgia, and New York (Wu et al., 1999). Latino respondents accounted for 30.4% of children identified as having “No Disorder,” and 25% of those identified as having a depressive disorder only (Wu et al., 1999). They also accounted for 13.9% of children with combined depressive and disruptive disorders and 12.5% of those with disruptive disorders only (Wu et al., 1999). The authors found that children with depressive disorders were less likely to use mental health services than those with disruptive disorders (Wu et al., 1999). In addition, Latino children had lower use of mental health services than White children but higher use rates than African American children (Wu et al., 1999). When the use of school-based services was examined, Latino children had higher use than their White counterparts (Wu et al., 1999). Overall, children and adolescents were more likely to use school-based mental health services than services outside of school (Wu et al., 1999). Limitations of the study included a lack of specificity about characteristics of the Latino sample such as preferred language, area of residence, and/or years living in the United States, which made it difficult to determine whether service utilization patterns for Latino children differed in Puerto Rico versus the United States. However, it is possible that differences in language and beliefs about mental health, illness, and service use between the two locations contributed to differential utilization rates, and should be considered in future research.

Alegría et al. (2004) focused on the help-seeking patterns of parents in Puerto Rico, whose children had impairments related to functioning in the home, community, school, or with friends (Alegría et al., 2004). The authors found that 65% of children identified as having impairments did not receive any mental health services, even though 61.4% of these children had a psychiatric diagnosis (Alegría et al., 2004). In addition, only 3.1% of impaired children used mental health services, while a slightly higher percent (3.7%) used school-based services (Alegría et al., 2004). Although overall utilization rates were low, the authors noted that caregivers who identified significant impairment in their children were four times more likely to seek mental health services (Alegría et al., 2004).

Studies with children suffering from depression have also pointed to differences in utilization of services related to gender, level of impairment/severity, family income and insurance coverage. Wu et al. (2001) examined patterns of service use among depressed children and adolescents in Westchester County, New York. The authors found that children diagnosed with depressive disorders were more likely to be male, minorities, from low-income families, and recipients of Medicaid (Wu et al., 2001). Overall, only 64% of children identified with symptoms of depression sought and received professional help for the condition (Wu et al., 2001). In contrast, 65% of Latinos were receiving help, but only 28% were taking antidepressant medications (Wu et al., 2001). Being Latino was not identified as a factor contributing to underutilization of services for depression (Wu et al., 2001). Instead, correlations were found between service use and gender (girls were more likely to receive services than boys), and level of impairment/severity of depression (Wu et al., 2001). While neither family income nor insurance coverage was correlated to service use, these variables did show some significance with regard to the use of antidepressant medication (Wu et al., 2001). Children

from families with higher income and/or private insurance were more likely to use antidepressant medication than those from low-income families and/or those with Medicaid coverage or insurance of any kind (Wu et al., 2001). The impact of income and insurance on certain aspects of care such as medication points to the need for researchers to more carefully articulate the components and types of utilization being examined as well as disparities related to racial/ethnic groups.

Nationally, utilization of services by Latino adolescents with emotional distress has been reported to occur primarily through schools (Kodjo & Auinger, 2004). Kodjo and Auinger (2004) used data from a nationally representative survey on adolescent health and health-related behaviors as the basis for identifying predictors of service use among emotionally distressed adolescents. The study focused on adolescents who scored in the top third of Resnick's emotional distress scale, which measures feelings of depression, loneliness, sadness, fear, and moodiness. Although the survey focused primarily on access issues and barriers, the authors were able to identify predictors of mental health service use for adolescents with emotional distress (Kodjo & Auinger, 2004). Overall, only 17% of the sample received psychological counseling with 34% of these adolescents receiving mental health services through school (Kodjo & Auinger, 2004). Latino adolescents reported receiving counseling at rates lower than their White counterparts (16% vs. 19%) but nearly double those of African American students (Kodjo & Auinger, 2004). The most significant predictor for use of mental health services among Latino adolescents was suicidality (Kodjo & Auinger, 2004). Negative predictors of service use specific to Latinos included living in an urban area and having barriers to care (Kodjo & Auinger, 2004).

Across studies on utilization it is important to note that types of services used in different communities, measures for diagnosis, and descriptions of symptoms vary. Because of this variation it is difficult to compare across studies with any confidence. Nevertheless, the observation can be made that it appears Latino children and adolescents are receiving services primarily through schools and would benefit from greater access to mental health counseling and other services, especially in cases of depression and suicidality.

Highlights

Despite frequent characterization of Latinos as a single ethnic group, great variety exists within this population. Population differences include geographic settlement patterns, language preferences, religious practices, racial identity, socioeconomic status, and levels of education. Acculturation levels also vary, and Latinos exhibit a wide variety in the degree of continued contact with their countries of origin. The degree of compatibility between Latinos and the mental health system can be enhanced by acknowledging the diversity of this population, learning more about characteristics within particular communities, and how these communities have interacted with service providers in the past.

A total of eight evidence-based strategies were identified in this chapter for use with Latino populations who are seeking mental health services for their children. Five of these strategies address issues related to service access, two address issues

Nationally, utilization of services by Latino adolescents with emotional distress has been reported to occur primarily through schools.

Engagement and outreach strategies were most often recommended in the literature reviewed for increasing access among Latinos.

of service availability, and only one strategy addressed service utilization among Latinos. Engagement and outreach strategies were most often recommended for increasing access among Latinos. Findings indicate that continued engagement with family members following an initial contact with a provider can increase the number of sessions attended by youth needing services (McKay et al., 1998). As a result of these findings, McKay et al. (1998) recommend providing staff training on intensive family engagement processes and skills to increase the use of services among urban minority youth with mental health needs. McMiller & Weisz (1996) also recommend that providers take more time with parents and families of Latino youth with mental health needs to address fears or concerns associated with the mental health service system. Another outreach strategy recommended for use with Latinos calls for the implementation of targeted outreach and public education that highlights the positive effects of services and treatments for children and young women, in particular, as well as help in identifying mental health symptoms (Alegria et al., 2004; Alvidrez, 1999).

The array of services that are available is a key issue in Latino communities and neighborhoods. Lack of insurance coverage or access to specialty services resulting in underutilization of mental health services are of particular concern. Adapting to the cultural and linguistic characteristics of the community, including ethnic specific services, and ethnic matching with personnel, are important strategies recommended for use with Latinos. The use of ethnically matched service providers was found to increase rates of treatment attendance, improvements in functioning and clinical outcomes, and overall service utilization in these populations (Gamst et al., 2004; Lau & Zane, 2000; Yeh, Takeuchi, & Sue, 1994).

Our analysis of the research literature resulted in identification of a number of direct service strategies to enhance compatibility between Latino populations and the mental health service system. These recommended direct service strategies are summarized here and presented in table form in Appendix C. For each direct service domain presented, issues related to compatibility between population characteristics and organizational characteristics are linked with the recommended evidence based strategies.

Service Access Recommendations

Key barriers to access that have been identified for Latino children and families are related to parental perceptions of barriers and parents' help-seeking behaviors. Mental health service access can be facilitated by working more closely with Latino parents to identify their attitudes and beliefs related to their child's mental health. Service delivery strategies that emerged from our analysis of the literature include:

- Incorporate the use of bilingual/bicultural engagement practices at multiple points of contact
- Involve families in assessment and intervention processes wherever possible
- Help families identify and eliminate barriers to treatment during the engagement process
- Implement training and supervision on engagement practices emphasizing the development of trust

Most Latino families are willing and able to help their children but are more likely to consult with family and other natural supports instead of mental health professionals or agencies. Many families also fear that services will be too expensive if the family lacks insurance, or that health insurance would not cover services or treatments. There are also fears that services might be intrusive or their children might be removed from the home or hospitalized. In addition, parents may perceive that a language barrier may exist if they approach an agency for assistance. Strategies to facilitate formal help-seeking among Latinos that emerged from our analysis of the literature include:

- Increase outreach to community leaders and Latino family members who may serve as initial points of contacts for Latino families with mental health needs
- Evaluate outreach efforts periodically to assess for increases in service use among targeted populations
- Obtain consumer input to develop innovative service delivery options, outreach efforts, and alternative service locations

In addition to increasing outreach efforts within Latino communities, research also highlights the importance of targeting education about mental health, services, and treatments to Latinos to increase understanding of how treatments and interventions can alleviate symptoms of mental illness in children. Strategies related to educating parents include:

- Educate parents and the community about the need for early intervention and the use of services when symptoms are less severe (increase understanding of the link between symptoms and child functioning)
- Educate families about available services and treatments
- Develop public health education campaigns to make the link between impairment and need for mental health care, and distinguish the need for professional help from help that can be provided by informal sources

Studies indicate that increasing engagement of parents can have a positive effect on the use of children's mental health services among Latinos. A number of strategies can increase the level of engagement between providers and Latino parents and their children. These strategies include:

- Use bilingual/bicultural engagement practices at multiple points of contact, such as telephone calls between an initial call and the intake appointment and before a treatment session
- Address hesitancy of parents who have difficulty disciplining their child in attending initial intake or continuing services for their child

Recommended service delivery strategies for increasing Latino access to services include:

- Involve families in assessment and intervention processes wherever possible
- Increase outreach to community leaders and Latino family members who may serve as initial points of contacts for Latino families with mental health needs
- Educate parents and the community about the need for early intervention and the use of services when symptoms are less severe (increase understanding of the link between symptoms and child functioning)
- Use bilingual/bicultural engagement practices at multiple points of contact, such as telephone calls between an initial call and the intake appointment and before a treatment session

Recommendations for increasing the availability of services for Latino populations include:

- Develop culturally/linguistically appropriate assessments and referral procedures
- Identify strategies or approaches used by ethnic specific providers that might be used effectively by mainstream providers
- Adopt the use of interpreters and cultural brokers, who help racially/ethnically diverse children and families navigate the mental health system

Service Availability Recommendations

The research available on ethnic specific services among Latinos points to an overall lack of Latino/Spanish-speaking providers. Availability of appropriate services affects both service access and utilization. Latinos who are recent immigrants or speak limited English, may find it difficult to identify appropriate services for their children. Moreover, the research suggests that the availability of appropriate mental health services for Latino children may also be limited because these are often not located in Latino neighborhoods or communities. Based on these findings, the following recommendations are made for agencies seeking to make services more available to Latino families:

- Develop culturally/linguistically appropriate assessments and referral procedures
- Identify strategies or approaches used by ethnic specific providers that might be used effectively by mainstream providers
- Refer to ethnic specific providers based on assessed need or preference of child or family
- Develop strategies for addressing the shortage of Latino providers
- Increase transportation and scheduling options
- Increase availability of bicultural and bilingual mental health staff through hiring and increased training, whenever possible
- Adopt the use of interpreters and cultural brokers, who help racially/ethnically diverse children and families navigate the mental health system

Service Utilization Recommendations

Research with Latino children and youth consistently identifies high rates of unmet mental health need. Insurance status, in particular, have been associated with unmet need among Latinos. Strategies for increasing utilization include:

- Improve methods for identifying mental health needs in Latinos
- Assess needs by aspects of care, such as psychiatric services and drug therapy
- Develop strategies to match types of services with the level and type of need
- Develop strategies to ensure Latino children receive specialty mental health services at sufficient frequency and intensity at earlier ages

Latino family utilization of mental health services is low in many areas. More research is needed to understand the reasons for low utilization of certain services and the characteristics of the Latino populations that are underutilizing them. Some research has suggested that utilization by Latino families is influenced by preferences for certain types of help, as well as lack of insurance coverage. Parents' beliefs about their child's disability and typical coping mechanisms impact whether they consider help to be necessary or appropriate. There is also a lack of awareness of educational and therapeutic needs and the types of help that are available. And, families may fear punitive consequences from formal agencies once their children's problems are made known. Our analysis of the literature suggests that differences in utilization rates for Latinos compared to other populations may be addressed as follows:

- Develop interventions that target entire Latino families
- Identify and address cultural differences in discipline
- Assess levels of family stress and social support
- Increase understanding about reasons for service preferences and satisfaction with services
- Reduce stigma associated with Latinos receiving mental health services
- Develop strategies for identifying and decreasing discrimination within provider agencies
- Assess the impact of cultural thresholds for symptomatology, use of alternative mental health services, and different beliefs about mental health/mental illness among Latino families
- Develop a variety of payment options in high poverty communities

Recommendations for increasing utilization of services among Latinos include:

- Develop interventions that target entire Latino families
- Assess levels of family stress and social support
- Increase understanding about reasons for service preferences and satisfaction with services
- Reduce stigma associated with Latinos receiving mental health services

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5

Research with Native American Populations

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The indigenous population of North America encountered by Europeans included a diverse number of ethnic groups with distinct linguistic and cultural attributes, political systems, and religious traditions.

Native American Populations

This chapter will present the current research base for examining the degree of compatibility between Native American children and their families and the mental health service system. The findings are presented based on the conceptual model described in chapter 1.

Background

The Native American population in the United States occupies a unique place in the social history of this nation. The population includes descendants of numerous ethnic groups that populated North America prior to the conquest and colonization of the continent by Europeans in the 15th Century. Identified in the U.S. Census by the term “American Indian and Alaska Native,” this population is defined as “people having origins in any of the original peoples of North and South America (including Central America) who maintain tribal affiliation or community attachment” (U.S. Census Bureau, n.d.). The American Indian and Alaska Native category includes individuals who reported their race as any one of the following: “American Indian,” “Alaska Native,” a principal or enrolled tribe, or one of the other race categories used in the Census combined with American Indian or Alaska Native. The indigenous population of North America encountered by Europeans included a diverse number of ethnic groups with distinct linguistic and cultural attributes, political systems, and religious traditions. Scholars disagree as to the number of indigenous peoples at the time that Europeans arrived – estimates range from 1 million to 18 million original inhabitants in North America alone (Stiffarm & Lane, 1992; Weaver, 1998).

The arrival of Europeans heralded centuries of widespread death and devastation for most, if not all, of the indigenous nations of the continent resulting mainly from aggressive warfare, disease, slavery, and enforced removal from traditional lands. Historical estimates suggest that between 95% and 99% of indigenous populations were eradicated between 1500 and 1900 (Stiffarm & Lane, 1992). Forced relocations of Indian nations from traditional lands in the 1800s resulted in the deaths of hundreds of thousands from disease, exposure, and malnutrition encountered during enforced marches over thousands of miles (Calloway, 2003; Norton & Manson, 1996). Following the end of the Civil War, the United States instituted a policy of forced assimilation to the “American way of life” by removing children from their homes and communities and placing them in boarding schools where they were forbidden to speak their native languages and observe cultural/religious beliefs and practices (Adams, 1995).

Former boarding school students have reported receiving harsh treatment (including verbal, physical, and sexual abuse) and severe punishments for speaking

Current social indicators

for Native Americans appear to place them at risk for a number of serious social and health concerns.

anything other than English and/or continuing cultural traditions or beliefs in schools where parents were often not able or allowed to visit (Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998; Fisher & Ball, 2002; Struthers & Lowe, 2003; Weaver, 1998). However, some historical scholars contend that the boarding school experience oftentimes reinforced the cultural beliefs and practices that the schools worked so hard to eradicate (Deyhle & Swisher, 1997). Although Native American ethnic communities and nations have maintained distinct cultural and religious beliefs, a collective history of resistance to colonization has fostered the development of a pan-Indian identity that transcends tribal affiliation and informs contemporary community and individual native identities (Davis, 2001).

According to the 2000 U.S. Census, the Native American population totaled 4.3 million or 1.5% of the total population. Since 1960, the population has grown by 250%, according to some estimates, due to increases in the number of individuals identifying as American Indian or Alaska Native, increases in the population's overall birth rate, decreases in Native American mortality rates, and changes in Census reporting procedures (United States Department of Health and Human Services [U.S. DHHS], 2001). The number of Native Americans residing on reservations and trust lands has decreased over the past two decades – only 1 in 5 remain in these areas and over one half of the population live in urban, suburban, or rural areas not associated with tribal lands (U.S. DHHS, 2001). This decrease in reservation populations was spurred by yet another forced resettlement program initiated by the Bureau of Indian Affairs following WWII (Norton & Manson, 1996). Currently, most Native Americans live in Western States, including Alaska, Arizona, California, Montana, New Mexico, and South Dakota, with 42% of the population living in rural areas.

Current social indicators for Native Americans appear to place them at risk for a number of serious social and health concerns, including higher morbidity and mortality rates than the general population (Snipp, 1996). The population is younger and has lower educational levels than non-Hispanic Whites. About 33% of the population was 18 years or younger in 2000, and the median age of 29 years is less than the national median age of 35 (Ogunwole, 2006). Although 71% of Native Americans aged 25 or older were high school graduates, only 12% had received a bachelor's degree (Ogunwole, 2006). As a result, a higher number of Native Americans were employed in non-professional industries, such as the service sector, construction, or production/transportation. Further, those who worked in full-time positions earned substantially less than the mainstream average for the nation (Ogunwole, 2006). The median income recorded for Native American households was \$30,599 in 1999. Yet, the per capita income for these households was \$12,893, and 26% of the total population was recorded as living below the poverty level. Forty-one percent of Native Americans living below the poverty level were younger than 18 years. Moreover, Native Americans had higher percentages of family households headed by one person than the total U.S. population. Single women headed 21% of all households, and single men headed nearly 8% of all households.

Historically, spirituality and native religions have played an important role in the lives of most Native Americans despite differences in beliefs and practices. Although distinct spiritual traditions exist within each ethnic group, certain general themes are recognizable (Young, 2001). Spiritual beliefs in Native American cultures are generally understood as informing all aspects of life, including a worldview that emphasizes harmony with nature, the earth, and/or the universe, and other human beings, and incorporates the cyclical and circular rhythms of natural phenomenon such as the four seasons, the four cardinal points, and/or celestial bodies (Struthers & Littlejohn, 1999; Young, 2001). Conflicts have arisen between various Native American groups and researchers whose representations of Native American cultures (especially spiritual practices) have resulted in oversimplifications or distortions with little benefits to the communities under study (Norton & Manson, 1996; Young, 2001). In spite of these drawbacks, research has contributed to understanding the contributions of traditional health or healing practices and rituals to improving health outcomes among Native Americans (Buchwald, Beals, & Manson, 2000; Dana, 2000; Marbella, Harris, Diehr, Ignace, & Ignace, 1998; Walters & Simoni, 2002). In addition, researchers have worked on developing a measure of enculturation, or degree of identification with identity of origin, to determine how family involvement in traditional rituals and activities might serve as a protective factor against negative health indicators (Zimmerman, Ramirez-Valles, Washienko, Walter, & Dyer, 1996).

The physical and cultural destruction experienced collectively by the Native American populations of this continent have left a legacy of unresolved grief and traumatic feelings of loss across generations and communities (Brave Heart & DeBruyn, 1998). In outlining the characteristics and effects of this concept within Native American communities, Brave Heart and DeBruyn (1998) use the literature on Jewish Holocaust survivors as a referent. As with the psychological literature on descendants of Holocaust survivors, historical trauma is thought to be transmitted from generation to generation and may have far-reaching psychological effects even on children who have not experienced the direct effects of atrocities (Kellerman, 2001). Native American scholars argue that destructive policies resulted in the oppression, repression, and even destruction of Native American cultures and communities over a period of more than 400 years. Federal policies toward Native American cultures and nations followed a generalized pattern of annihilation (characterized by aggressive warfare and land acquisition, introduction of diseases into communities, and prohibition of religious and cultural traditions), followed by assimilation (characterized by the boarding school and relocation policies of the 1940s through 1960s), and then, “reservation termination policies that sought to minimize federal relationships with tribes” (DeBruyn, Chino, Serna, & Fullerton-Gleason, 2001, p. 90). Researchers point to historical trauma as a result of these policies and as the cause for the numerous social and health related problems afflicting many Native American communities in the present day, and especially link them to mental health problems (Brave Heart & DeBruyn, 1998; DeBruyn et al., 2001; Fisher & Ball, 2003; Struthers & Lowe, 2003; Walters & Simoni, 2002).

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Lack of trust in formal service providers has been identified as an important barrier to mental health service utilization among Native Americans.

Native Americans and Mental Health

The mental health research literature related to Native Americans is limited, but growing. As of the publication of the Supplement to the Surgeon General's Report (U.S. DHHS, 2001), a large-scale prevalence study of the population had yet to be conducted and national representative studies have generally failed to generate samples large enough for analysis (Johnson & Cameron, 2001; Norton & Manson, 1996; Sue & Chu, 2003). Small-scale studies have been conducted with specific communities or ethnic groups and have found high prevalence rates of psychiatric disorders— especially depression— and higher rates of substance abuse and suicide (D'Andrea, 1994; Gurley, Novins, Jones, Beals, Shore, & Manson, 2001; Indian Health Service, 2001; Johnson & Cameron, 2001; Kinzie, Leung, Boehlein, Matsunaga, Johnson, Manson, Shore, Heinz, & Williams, 1992; La Fromboise, Berman, & Sohi, 1994; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997; Sack, Beiser, Baker-Brown, & Redshirt, 1994; Sue & Chu, 2003; Walters & Simoni, 2002; Yates, 1987; Zitzow & Desjarlait, 1994). Previous negative experiences with researchers and/or negative consequences following publication of research results has engendered a general lack of trust among Native Americans and increased challenges to recruitment of Native subjects in research studies, especially those focused in areas of health and mental health research (Norton & Manson, 1996). Research on mental health among Native Americans has focused on the population's negative experiences of historical trauma and oppression, including official government prohibitions against indigenous health practices (D'Andrea, 1994; Dana, 2000; Fisher & Ball, 2003; Guilmet & Whited, 1989; O'Neil, 1996; Tafoya & Del Vecchio, 1996; U.S. DHHS, 2001), and the detrimental effects of enforced isolation among former boarding school students across generations (Johnson & Cameron, 2001). Lack of trust in formal service providers, resulting from these collective historical experiences, has been identified as an important barrier to mental health service utilization among Native Americans (Johnson & Cameron, 2001; Rodenhauer, 1994). Because of contentious relationships between Native Americans and researchers and/or government entities, various researchers recommend employing techniques that promote community collaboration throughout the research process (Baldwin, 1999; Beauvais, 1999; Fisher & Ball, 2003; Fleming, 1994; LaFromboise & Howard-Pitney, 1994; LaFromboise, Trimble, & Mohatt, 1990; Mohatt, 1989; O'Neil, 1982).

As with other ethnic groups, the health beliefs and traditional health systems of Native Americans differ from the mainstream (Cohen, 2003; Guilmet & Whited, 1989; Johnson & Cameron, 2001). Diagnosis of mental illness has been identified as problematic due to misunderstanding of indigenous health beliefs among Western providers and an incongruity between Western mental health concepts and those found among various Native American groups (Earle, 1998; O'Neil, 1996). Researchers have identified behaviors and other physical manifestations of cultural beliefs, such as hallucinations and "prolonged mourning" that may be misdiagnosed as severe mental health symptomatology (Earle, 1998; Manson, Shore, & Bloom, 1985; O'Neil, 1989; Price-Williams, 1987; Wallace, 1959). Moreover, different ethnic groups have specific concepts related to emo-

tional ailments that have no direct translation into English (Johnson & Johnson, 1965; Kleinman, 1988; Lewis, 1975; Manson et al, 1985; Trimble, Manson, Dinges, & Medicine, 1984). Medical anthropologists suggest that definitions and diagnoses of mental disorders and illness must be understood as “rest[ing] on culturally distinct notions of normality and pathology” (O’Neil, 1996, p. 207).

The literature on mental health need among Native American children and youth is limited, although a number of studies suggest that Native American youth, in particular, have higher prevalence rates of some disorders and symptoms (Indian Health Service [IHS], 2001; Johnson & Cameron, 2001; U.S. DHHS, 2001; Yates, 1987). More than half of Native American youth surveyed by the IHS (2001), reported being depressed, and the suicide rate for youth ages 15 to 24 was 2.8 times higher than non-Hispanic White youth. Various studies indicate that 20% of Native American girls have attempted suicide (D’Andrea, 1994; Johnson & Cameron, 2001; LaFromboise et al., 1994). In a study conducted in Appalachia, Costello, Farmer, Angold, Burns, and Erkanli, (1997) found that Native American and non-Hispanic White children (aged 9 to 13) had similar rates of psychiatric disorders, including anxiety, depressive, and conduct disorders and ADHD. However, alcohol abuse among Native American 13 year olds accounted for nearly all of the substance abuse recorded in the study (Costello et al., 1997). Similarly, a study conducted in Nome, Alaska found that alcohol, inhalant abuse, and attempted suicide were the most frequent problems for which Eskimo youth sought services in a community mental health center (Aoun & Gregory, 1998). Researchers have also found a higher mental health need among a variety of Native American youth attending boarding schools (IHS, 2001; Johnson & Cameron, 2001; Kleinfeld & Bloom, 1977; Yates, 1987).

Findings

The number of research articles reviewed for this chapter was quite small (n=10). Within this pool of articles, two focused on measuring cultural responsiveness among Native and non-Native practitioners delivering mental health services to Native American children. Five of the articles clearly delineated research findings focused on testing interventions with Native American children and adolescents or measuring prevalence, risk and protective factors, and service utilization rates in specific tribal communities. One article presented service utilization findings of a large statewide study in which Native American youth comprised 3% of the overall sample. Another article presented a description of mental health services provided to Native American children and adolescents with serious emotional disturbance (SED) through Circles of Care (CoC) communities. One article presented findings from a study measuring perceptions of loss and associated negative mental health effects of parents experiencing historical trauma. Overall, the research focusing specifically on the mental health needs of Native American children and youth is quite limited (see Table 4).

One apparent reason for the limited number of such articles probably stems from the lack of available mental health services in rural and tribal areas. Several authors noted the general lack of mental health resources within Native

Overall, the research focusing specifically on the mental health needs of Native American children and youth is quite limited.

Table 4
Summary of Literature Review Articles: Native American

Citation	Sample			Issues Addressed	Domain
	Participants	Location	Age		
Allen et al. (2004)	NA Only (AI, AN)	10 SOC communities nation-wide	Children; SED	Information Systems; Modes of Delivery; Organizational Funding/Resources; Service Coordination; Systems	Access Availability
Beals, et al. (1997)	AI; N=190	Northern Plains reservation	Adolescents; 8th – 11th grade students	Co-morbidity of Substance Abuse and Disorders; Prevalence Rates; School-based;	Utilization
Bending (1997)	N =34 (NA Only)	WA	Child Welfare Practitioners	Cultural Training; Evaluation of Training; Service Delivery	Availability
Boyd-Ball (2003)	N=60 (NA Only)	Pacific Northwest	12-18; Children & Families	Barriers; Family Intervention; Family Management; Outcomes; Source of Referral	Availability
Cummins et al. (1999)	AI & AN; N=13,454	50 tribes; 12 Indian health service areas nationally	Children and Adolescents; 7th – 12th grade students	Protective Factors; Risk Factors; Resilience	Characteristics of the Population
Duclos et al. (1998)	AI; N=150	Northern Plains reservation	12-18; Juvenile Detention Detainees	Co-morbidity of Substance Abuse and Disorders; Prevalence Rates	Utilization
Maynard et al. (1997)	N =32,452 (1,531 AA, 900 API, 2,167 L, 1,011 NA, 26,843 W)	WA; Public, Outpatient MHS	All Ages	Intensity & Types of Services	Access Availability Utilization
Novins et al. (1999)	AI; N=150	Northern Plains reservation	12-18; Juvenile Detention Detainees	Co-morbidity; Prevalence Rates; Utilization Rates	Utilization
Novins, et al. (2004)	AI	9 Circles of Care grantees	Adolescents and adults	Community needs & resources	Access Availability Utilization
Whitbeck et al. (2004)	AI	2 reservations in the upper Midwest	Parents of Children aged 10-12	Historical Trauma; Perceived Loss; Prolonged Grief	Characteristics of the Population
Yurkovich et al. (2002)	N = 13 (NA Only)	2 AI Reservations	Mental Health Professionals	Program Development; Service Delivery; Service Types	Availability Utilization

Note. AA=African American, AI= American Indian, AN=Alaska Native, API=Asian/Pacific Islander, L=Latino, NA=Native American

American communities, which often necessitates removal of adolescents from their homes (Allen, LeMaster, & Deters, 2004; Beals, Piasecki, Nelson, Jones, Keane, Dauphinais, Red Shirt, Sack, & Manson, 1997; Duclos, Beals, Novins, Martin, Jewett, & Manson, 1998). Additional barriers identified by researchers that further complicate access include geographic distribution of services, limited transportation, and a lack of culturally/linguistically competent service providers (Allen et al., 2004; Novins, LeMaster, Jumper Thurman, & Plested, 2004). While one statewide study on utilization of services found that Native American youth generally had use rates that were comparable to those of non-Hispanic Whites,

two articles noted that incarcerated Native American youth most often accessed services through the juvenile justice system following arrests for juvenile status offenses (e.g. truancy, runaway, curfew violations, etc.) (Duclos et al., 1998; Novins, Duclos, Martin, Jewett, & Manson, 1999).

The small number of articles devoted to the mental health needs of and specialty service delivery to Native American children and youth makes generalizability of findings difficult across the diverse groups found within the Native American population. As Fisher and Ball (2003) note, the variability of cultural groups and languages found within the larger Native American population often necessitates a community-level or tribal-level intervention with considerable community participation in the study or intervention design and implementation in order to achieve positive outcomes. However, such tailored designs also limit the degree to which findings and interventions may be transposed to other communities without the same degree of community adaptation and participation. A number of authors noted this limitation within their findings and recommended additional research on the instruments or measures they used with diverse Native American groups, in order to increase the degree to which their findings might be more generally applicable to the Native American population as a whole (Allen et al., 2004; Beals et al., 1997; Boyd-Ball, 2003; Cummins, Ireland, Resnick, & Blum, 1999; Duclos et al., 1998; Novins et al., 1999; Whitbeck, Adams, Hoyt, & Chen, 2004).

Cultural/Linguistic Characteristics of the Population

The cultural/linguistic population characteristics shown in the conceptual model interact with an organization's/system's combined policies, structures, and processes (Hernandez & Nesman, 2006). The area of compatibility represents the potential for improving outcomes by reducing mental health disparities. This section will discuss studies that examine the highlighted section of the model and provide pointers for enhancing compatibility.

Research indicates that the negative mental health effects of historical trauma experienced by Native Americans can be measured empirically. Whitbeck et al. (2004) developed two scales designed to measure perceived loss and the feelings associated with these among parents of Native American children aged 10 through 12 years. Although none of the respondents to whom these scales were administered had experienced enforced separation from their families in boarding schools or some of the more extreme privations experienced by earlier generations of Native Americans, results of the Historical Loss Scale found that 20% to 50% of respondents thought daily about one or more forms of loss enumerated by the scale (Whitbeck et al., 2004). The second scale, which measured symptoms associated with historical loss, found that emotional responses most often associated with historical loss were: "sadness and depression, anger, intrusiveness of the thoughts (about historical loss), discomfort around White people, and fearful or distrustful of White people" (Whitbeck et al., 2004, p. 125). Because the scales were developed and used with a particular Native American ethnic group, it was recommended that additional research investigate the generalizability of the scales



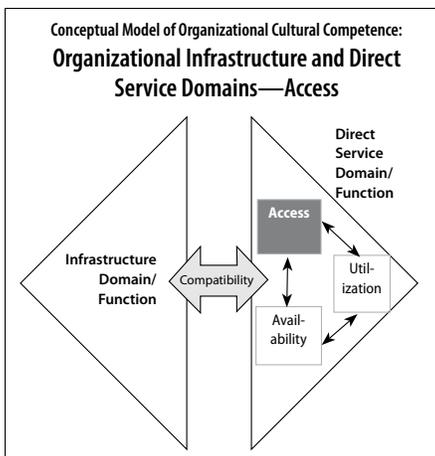
across diverse Native American ethnic populations, the severity of symptoms caused by historical loss, and the relationship between thoughts of historical loss and “more proximal stressors” such as poverty to emotional distress (Whitbeck et al., 2004, p. 128). Despite these limitations, the study indicates that perceived loss as a result of a collective experience of historical trauma remains an important consideration in understanding emotional health among Native American populations. While studies on Native Americans tend to focus on the negative effects of historical trauma, recent research indicates that Native American adolescents demonstrate resilience in the face of a number of adverse environmental and family stressors (LaFromboise, Hoyt, Oliver, & Whitbeck, 2006).

Despite the considerable environmental and other risk factors that may contribute to decreased mental health among Native American children and adolescents, a number of protective factors have also been found that increase the resiliency in Native youth (Cummins et al., 1999). Cummins et al. (1999) found that among all youth attending tribal schools in the 7th through 12th grades, the strongest correlates of emotional health were family caring and feeling of pride about their bodies. For female students, other important variables included the level of connectedness to school and the degree to which they worried or focused on concerns (Cummins et al., 1999). Other correlates of emotional health found among male students included parental expectations and having a particular skill or competence (Cummins et al., 1999). The authors recommended additional research focusing on interventions that utilize these protective factors to increase resiliency among Native American youth. Also recommended are studies that further explain how these factors protect Native American youth from possible negative effects of extreme poverty and social isolation found within some tribal communities.

Access

Access interacts with availability and utilization to form the direct service domains. A culturally competent organization seeks compatibility between the direct service domain and the infrastructure domain to form a combined set of policies, structures, and processes that will enhance services for culturally and linguistically diverse children and families. This section will discuss studies that examine the highlighted section of the figure and provide pointers for enhancing compatibility.

In a number of Circles of Care communities that provide services for Native American children and youth with serious emotional disturbances (SED), decreased access to services was generally attributed to limited services in the community, lack of transportation, lack of knowledge about services, and lack of culturally or linguistically competent providers and services (Allen et al., 2004). For example, Alaska Native families seeking services for SED youth reported that residential services they were referred to were located in urban areas, making it difficult for rural residents to reach them (Allen et al., 2004). For most Native American communities, resources and services specifically targeting children’s mental health were relatively unavailable, making health and social service provid-



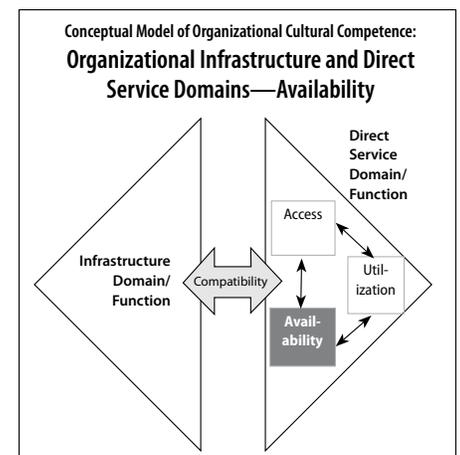
ers, juvenile justice, or the educational system the main access points for SED children and youth (Allen et al., 2004). In addition, many parents did not have telephones or transportation, and encountered scheduling difficulties or cancelled appointments, as well as difficulties finding ways to pay for services (Novins et al., 2004). Many families whose children experienced SED were simultaneously dealing with their own issues of domestic violence, substance abuse, and mental illness, which also impacted access (Novins et al., 2004). Youths who are in need of services have also been described as being wary of mental health services, often avoiding seeking help until referred by the court system (Novins et al., 1999). Because of these and related structural and social challenges, community resources such as extended kinship networks, Native language programs, involvement in ceremonies, and participation in community organizations such as churches, recreational, and educational programs are suggested as important ways to access supports for Native American families (Novins et al., 2004).

Of seven Native service systems surveyed for the Circles of Care initiative, four mentioned a lack of culturally competent services as a prime barrier to families seeking services, particularly a lack of family-based services that incorporate traditional spiritual and cultural practices (Allen, et al., 2004). In their needs assessments, many communities also identified barriers such as a lack of providers who speak the language or are familiar with the cultures represented by the families they serve (Novins et al., 2004). Urban communities in particular have identified access barriers such as the need for cultural competency and linkage between school, health and social service in order to ensure access to the many available services (Novins et al., 2004). Despite many identified barriers, local cultural competence strategies for incorporating traditional values and natural resources within the community have been identified (Allen et al., 2004). Some examples given are programs that incorporate entire classrooms without singling out the target child, and needs assessments that incorporate adolescents from the community (Allen et al., 2004).

Availability

Availability, together with access and utilization, form the direct service domains. This section will discuss studies that examine the highlighted section and provide pointers for enhancing compatibility between the direct service functions and the organizational infrastructure.

Much of the literature on research with Native American populations acknowledges the importance of recognizing historical trauma and its negative effects on emotional and mental health (Boyd-Ball, 2003; Dana, 2000; DeBruyn et al., 2001; Earle, 1998; Fisher & Ball, 2002; Fisher & Ball, 2003; Johnson & Cameron, 2001; Norton & Manson, 1996; U.S. DHHS, 2001; Walters & Simoni, 2002; Weaver, 1998; Weaver, 1999; Yurkovich, Clairmont, & Grandbois, 2002). As tribal communities work to reintegrate traditional practices and beliefs in the social fabric of their communities, programs often focus on the importance of family involvement in important ceremonies and events as part of social, health, and mental health interventions (Fisher & Ball, 2002; Fleming, 1994). It has also been pointed out that prevention and early inter-



Mental illness has become the top health problem identified by most IHS facilities (Johnson & Cameron, 2001).

vention services for Native Americans must incorporate the unique cultural and historical characteristics of particular communities in order to effect change beyond the individual level (Fisher & Ball, 2002). The limited number of mental health services for Native Americans living on reservations or in isolated rural areas presents challenges to creating such innovative interventions by requiring their development without an existing infrastructure (Johnson & Cameron, 2001; Rodenhauser, 1994). Yet, these interventions are crucial, as mental illness has become the top health problem identified by most IHS facilities (Johnson & Cameron, 2001). Increases in the IHS mental health budgets should provide opportunities for developing innovative programs available to isolated Native American communities.

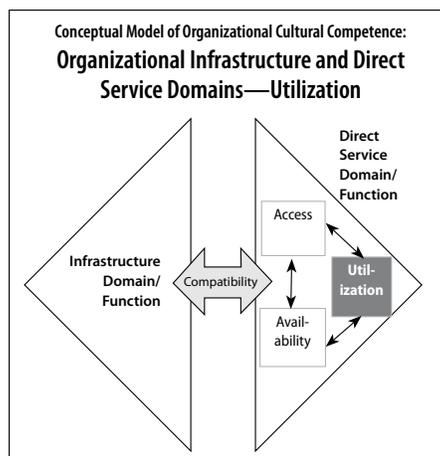
For Native American adolescents with substance abuse issues, in particular, treatment often involves leaving their community and family to enter inpatient treatment in one of 12 Indian Health Service treatment facilities, many miles from home (Boyd-Ball, 2003). This treatment reality evokes the history of enforced removals of Native children to boarding schools and engenders mistrust and resistance in the population (Boyd-Ball, 2003). In an effort to mitigate the possible negative effects that isolation from family and community might have to successful treatment, one study entitled, “The Shadow Project” was implemented to offer culturally relevant, “family-enhanced” inpatient drug and alcohol treatment (Boyd-Ball, 2003). The eight-week program was provided in a treatment facility in the Pacific Northwest to youth aged 12 to 18 years from various Western states and provided youth with opportunities to participate in a number of traditional practices, rituals, and activities, and permitted home visits to attend traditional events with family (Boyd-Ball, 2003). Family involvement in the program also extended to the planning stage, where a parent or caregiver met with the therapist and agreed to components of the treatment plan. Interviews were conducted with parents using a culturally responsive technique to elicit self-assessment (Boyd-Ball, 2003). The treatment plan also included a Welcome Home Ceremony that built family and community support for the adolescent upon returning home and eased re-entry to the home. Further, the program provided for training to follow-up workers from the community in “motivational interviewing techniques” to facilitate four components of aftercare, including “parent monitoring, reducing peer clustering, maximizing family engagement, and being culturally responsive...by recognizing historical events and their effect on the family” (Boyd-Ball, 2003, p. 1358). Shadow Project participants reported perceiving themselves as having a high level of support from family members, adults outside their family, and their peers, and they maintained levels of abstinence from drug and alcohol use similar to a control group in the year following treatment (Boyd-Ball, 2003). A 63% participation rate for the overall project was attributed to culturally responsive treatment in conjunction with culturally responsive research (Boyd-Ball, 2003).

Training programs have been found to improve availability of services by increasing worker proficiency in cultural sensitivity practices and implementation of federal policies for children’s service systems. The “Teaming for Indian Families” program was created through partnership between the University of Washington,

the state Department of Social and Health Services, and 26 federally recognized tribes in the state of Washington to develop a “culturally sensitive model of practice” for child welfare workers (Bending, 1997, p. 153). The program established a training curriculum with a focus on culturally competent implementation of the Indian Child Welfare Act of 1978 (ICWA) for state and tribal workers, presented in five two-day training sessions, given over a four-month period. Using pretest and posttest data and follow-up interviews with training participants, Bending (1997) found significant improvement in training participant attitudes about the importance of considering cultural factors when assessing child welfare cases. However, participants showed no significant increase in attitudes related to implementation of specific ICWA standards or reducing Native American welfare removals (Bending, 1997). Follow-up interviews with Native and non-Native participants indicated greater cooperation between them once in the field and reported feeling better equipped to make culturally sensitive assessments and to complete ICWA compliance forms, as well as developing rapport with Native American families (Bending, 1997). Despite these positive outcomes, participants indicated a need for greater support in the implementation of ICWA standards, suggesting a need for greater linkages at administrative, state, and tribal levels and streamlining of bureaucratic requirements.

The provision of culturally competent care for Native American youth requires much more than matching the ethnic/cultural backgrounds of therapist and patient (Yurkovich et al., 2002). While literature and training materials on culturally competent care focuses on service delivery in cross-cultural contexts, less attention is given to challenges that may arise between providers and consumers of the same ethnic or cultural background (Buchwald, Caralis, Gany, Hardt, Johnson, Meuche, & Putsch, 1994; Purnell & Paulanka, 1998; Yurkovich et al., 2002). In a study conducted with Native American nurses, Yurkovich et al. (2002) investigated the different approaches they bring to their encounter with Native American patients to assess therapists’ awareness of within group differences in cultural preferences and beliefs. Therapists who are not aware or do not recognize differences within their own cultural or ethnic groups “approach their clients based on personal assumptions of ‘Indianness’” and therefore to do not focus care to include traditional healing practices or activities (Yurkovich et al., 2002, p. 153). Those who accept or assume that cultural differences exist between themselves and their patients were found to be more likely to actively suggest the incorporation of traditional practices, activities, etc. and invite use of these. Yurkovich et al. (2002) suggested incorporation of a thorough cultural assessment during intake to develop trust and respect between provider and patient and make the patient central to his/her healing. However, the authors acknowledge that such enhanced intake procedures may be difficult to implement because of time and/or billing constraints. In spite of these recommendations, the authors question the feasibility of incorporating culturally responsive service practice with Western medical practices, and suggest further study is needed to understand how Native Americans with severe mental illness can effectively maintain wellness while receiving services from non-Native providers (Yurkovich et al., 2002).

Providers who accept or assume that cultural differences exist between themselves and their patients were found to be more likely to actively suggest the incorporation of traditional practices, activities, etc. and invite use of these.



Utilization

Utilization forms the final direct service function. This section will discuss studies that examine the highlighted section and provide pointers for enhancing compatibility between the direct service functions and the organizational infrastructure.

Studies have indicated that Native Americans are overrepresented in emergency care and inpatient settings, suggesting that specialty providers are not the first stop when mental distress symptoms appear (Snowden, 2003). In addition, when mental health problems are identified, Native Americans are more likely to be placed in restrictive settings away from their families and communities (Snowden, 1999; Snowden, 2003). However, as the Supplement to the Surgeon General's Report (U.S. DHHS, 2001) and other researchers note, "[t]here are conflicting results about racial differences in the use of both inpatient and outpatient mental health services" (Maynard, Ehreth, Cox, Peterson, & McGann, 1997, p. 411). A study on utilization of public mental health services between five racial/ethnic groups in Washington State found that utilization rates of Native American adolescents matched those of non-Hispanic Whites in services such as individual treatment, group treatment, day treatment, and crisis services (Maynard et al., 1997). Native Americans were less likely to use medication management services, but were more likely to use family therapy than Whites (Maynard et al., 1997). Such differences in utilization rates suggest the need for additional research to understand preferences and help-seeking processes for Native American youth and their families in specific communities.

Differences in diagnoses and utilization rates for specific treatments for Native American youths compared to non-Native youths suggest a need for more attention to these areas in research and program design. A study conducted with American Indian adolescents living in a large Northern Plains community found a higher prevalence of substance abuse and disruptive behaviors than comparison samples of non-Indian youths (Beals et al., 1997). Studies conducted with Native American adolescent detainees have also indicated high prevalence of both mental health disorders and substance abuse (Duclos et al., 1998; Novins et al., 1999). Native American adolescents are commonly arrested or detained for truancy, curfew violations, or property destruction, and often are dually diagnosed for substance abuse and disruptive behavior disorders (Duclos et al., 1998; Feld, 1995; Novins et al., 1999). However, only the most severely affected detainees are receiving treatment for emotional problems (Novins et al., 1999). Prevalence of comorbidity and greater involvement with the courts suggests that Native American youth could benefit from greater emphasis on prevention and early intervention.

Duclos et al. (1998) suggest that because of a lack of available mental health services, the juvenile justice system appears to be the main form of mental health intervention available to Native American youths. However, the types of services that are used by youths who go through the courts tend to be those related to substance abuse rather than to emotional problems. Higher percentages of Native American adolescent detainees also report having used substance abuse services (38%) compared to those using mental health services (29%) (Novins et al.,

1999). Residential treatment was reported as the most often used service for substance abuse, while emotional problems were most often served in outpatient facilities (Novins et al., 1999). About one-fourth of the youths sampled by Novins et al. (1999) reported use of traditional healing methods and pastoral counseling for both substance abuse and emotional problems. However, the majority of youths in detention who suffered from psychiatric disorders did not report using any services for alcohol, drug or mental health problems. Development of appropriate mental health screening methods that could be made available to key stakeholders such as the juvenile justice system are recommended in order to increase evaluation and treatment options for Native American youths (Duclos et al., 1998; Novins et al., 1999).

Highlights

Since the arrival of Europeans in the 15th Century, Native American populations have experienced physical and cultural losses that decimated most of the original inhabitants of the North American continent (Stiffarm & Lane, 1992). The physical and cultural destruction experienced collectively by Native Americans has left a legacy of unresolved grief and traumatic feelings of loss across generations and communities, identified by researchers as “historical trauma” (Brave Heart & DeBruyn, 1998). Despite such difficulties, resilience and resistance in Native American populations has been supported by reliance on extended family and community networks, as well as traditional spiritual beliefs and cultural practices (Buchwald, Beals, & Manson, 2000; Dana, 2000; Marbella, Harris, Diehr, Ignace, & Ignace, 1998; Walters & Simoni, 2002; Zimmerman, Ramirez-Valles, Washienko, Walter, & Dyer, 1996).

A total of five direct service strategies for working with Native American children and/or adolescents and their families were identified from the articles reviewed in this chapter. Two strategies related specifically to mental health service access and three strategies addressed availability issues with Native American communities. Both studies recommend involving a family’s extended networks and cultural or spiritual resources, where appropriate, to increase the availability of appropriate supports (Novins et al., 2004; Allen et al., 2004). Such strategies should be made available but families should retain the last word on whether such enhancements are used or helpful for their children. Intake procedures that develop trust among Native clients and assess for ways to enhance cultural and spiritual resources are recommended for increasing the degree to which Native parents participate in their children’s healing (Yurkovich, 1998). While the use of such enhancements and resources make existing services more culturally responsive (Boyd-Ball, 2003), services must be tailored to specific ethnic groups and families in order for them to be fully culturally competent. The incorporation of family and cultural resources in existing services requires cultural sensitivity training and ongoing support for personnel working with Native populations (Bending, 1997). Such training is needed for Native, as well as non-Native providers, because of the diversity among Native Americans (Bending, 1997).

Recommended service delivery strategies for

increasing Native American access to services include:

- Consider the impact of historical trauma on the emotional health of Native American children and families
- Assess and address infrastructure barriers
- Incorporate a thorough cultural assessment into intake procedures
- Address issues of distrust or reluctance in seeking formal mental health services
- Identify and promote protective factors among Native American youth

Recommended service delivery strategies

for increasing the availability of services for Native American populations include:

- Incorporate important Native American traditions in therapeutic interventions when requested by families and involve families throughout treatment process
- Train Native and non-Native providers to accept cultural differences and to allow for incorporation of traditional practices when requested and appropriate
- Conduct culturally responsive research and evaluation to verify effectiveness of interventions
- Enhance linkages with policymakers and funding sources

Our analysis of the research literature resulted in identification of a number of direct service strategies to enhance compatibility between Native American populations and the mental health service system. These recommended direct service strategies are summarized here and presented in table form in Appendix D. For each direct service domain presented, issues related to compatibility between population characteristics and organizational characteristics are linked with the recommended evidence based strategies.

Service Access Recommendations

It is important to assess local barriers for Native American youths, which may include internal family characteristics, service system characteristics, or larger community and societal issues. Native American children and youth living in urban areas often have very different experiences compared to children living on reservations. For many, a general lack of services that are affordable, long distances to get to services, and lack of personnel who are familiar with specific cultural practices may hinder the initiation of seeking help. In many cases adolescents are removed from the home when problems arise, separating them from their families and communities and exacerbating problems or needs. Strategies to increase access to mental health services for Native American children and families that emerged from our analysis of the literature include:

- Consider the impact of perceived loss and historical trauma on the emotional health of Native American children and families
- Assess and address infrastructure barriers such as limited services in the community, lack of transportation, lack of telephones, lack of payment options, and scheduling limitations
- Incorporate a thorough cultural assessment into intake procedures
- Address issues of distrust or reluctance in seeking formal mental health services
- Identify and promote protective factors among Native American youth such as family caring, connectedness to school, and specific skills or competencies

Service Availability Recommendations

Maintaining ties to cultural ceremonies, native language, and extended family or tribe are important but difficult for Native American youths and families who do not live in close proximity to other members of their group. Yet, these resources can be important in improving the well being of Native American youths. Mental health providers can assist in reconnecting these youth to their cultural identities as part of their treatment approaches, and should provide options based on the preferences expressed by youth and families. Emergent strategies to increase availability for Native American children and families include:

- Develop prevention and early intervention efforts that incorporate the unique cultural and historical characteristics of particular Native American communities

- Incorporate important Native American ceremonies into therapeutic interventions when requested by families and involve families in treatment
- Involve family members in development of treatment plans using culturally responsive techniques to elicit self-assessment
- Train Native and non-Native providers to accept cultural differences and to allow incorporation of client's traditional practices and activities when requested and appropriate
- Conduct culturally responsive research and evaluation that can verify effectiveness of interventions
- Enhance linkages with policymakers and funding sources to better support culture-specific strategies for Native American children and families
- Provide resources for time and/or billing procedures that allow for enhanced engagement procedures

Service Utilization Recommendations

Utilization of mental health services by Native children is influenced by resource availability and diagnoses and/or identified needs. Native American youth tend to be identified for disruptive behaviors and substance abuse, and often enter mental health services through the courts, child welfare and/or substance abuse programs. A change in perspective about maintaining the well being of Native American youths is needed in order to change the current patterns of utilization. This might include a focus on protective factors and strengths and early identification and prevention initiatives that involve Native American youth and families in their own healing and maintenance of balance. Emergent strategies for services providers to increase utilization for Native American children and families include:

- Assess local utilization rates for Native American children and adolescents in the community, especially with regard to outpatient treatment and more restrictive placements
- Develop mental health screening methods to be used by key stakeholders such as the juvenile justice system to ensure appropriate referrals
- Incorporate family and cultural preferences for types of treatment and medication use

Recommendations for increasing utilization of services among Native Americans include:

- Assess local utilization rates for Native American children and adolescents in the community, especially with regard to outpatient treatment and more restrictive placements
- Develop mental health screening methods to be used by key stakeholders such as the juvenile justice system to ensure appropriate referrals
- Incorporate family and cultural preferences for types of treatment and medication use

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6

Research Findings Across Populations

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The literature points to multiple factors that combine to create disparities, including help-seeking characteristics, improper diagnoses or referrals, lack of early intervention, lack of cultural/linguistic adaptations, and lack of adaptations in financing.

Research Findings Across Populations

The literature reviewed for this monograph provides information that can assist in operationalizing cultural competence as presented in the conceptual model (Hernandez & Nesman, 2006) presented in Chapter 1. This model, which focuses on access, availability, and utilization of mental health services, can provide a guide for the incorporation of key strategies within organizations to increase overall cultural competence. Table 5 contrasts findings of research-based evidence across the racially/ethnically diverse populations targeted in this study that support the development and implementation of culturally competent direct service strategies. The table is followed by a discussion of findings, including recommendations for additional research needed to address gaps in the literature.

The link between lack of access to appropriate mental health services and supports and health disparities has emerged as an important area of focus (New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Resources [U.S. DHHS], 1999). Accordingly, this monograph examined literature available through typically accessed bibliographic databases in order to provide an assessment of the current status of research related to access and disparities in children's mental health services. The conceptual model (Hernandez & Nesman, 2006) that emerged from the literature review supports the New Freedom Commission (2003) and Surgeon General Report (U.S. DHHS, 1999) recommendations by emphasizing the importance of systemic and organizational awareness and responsiveness to the community as a component of cultural competence. Also key is the attention that must be given to the role of culture in all aspects of mental health service provision, independently and in conjunction with factors such as socioeconomic status (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebniak, & Baydar, 2002; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003; Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, & Landsverk, 2002).

Understanding Historical and Cultural Characteristics of Underserved Populations

Findings of this review reinforce the call to reduce disparities in access, availability, and utilization of services in racially/ethnically diverse communities (Huang, 2002). The literature points to multiple factors that combine to create disparities, including help-seeking characteristics, improper diagnoses or referrals, lack of early intervention, lack of cultural/linguistic adaptations, and lack of adaptations in financing. It also identifies particular historical and cultural factors for each population that should be better understood by providers in order to develop strategies that improve access, availability, and utilization of children's men-

When working with African Americans and Native Americans, in particular, providers must recognize and acknowledge complex socio-historical factors (such as government-sanctioned oppression and institutional discrimination) and the effects of these shared cultural experiences in order to address persistent mistrust in health research and treatment, overall.

tal health services. These multiple factors must be addressed through policies and procedures that consider a particular population's history and experiences within the mental health system, and the ways in which organizational factors can work to more positively shape that population's interaction with the service system.

For Native Americans and African Americans in particular, a history of government sanctioned oppression, institutional discrimination and the effects of these shared cultural experiences must be acknowledged by service providers in order to address persistent mistrust in health research and treatment, overall. Mental health researchers have examined the concept of historical trauma and the collective losses suffered by Native populations as a root cause for various social and health related problems afflicting many Native American communities in the present day, and especially link these problems with serious mental health issues (Brave Heart & DeBruyn, 1998; DeBruyn, Chino, Serna, & Fullerton-Gleason, 2001; Fisher & Ball, 2003; Struthers & Lowe, 2003; Walters & Simoni, 2002). Compounding the distrust caused by this collective historical experience are conflicts that have arisen between various Native American populations and mainstream researchers whose representations of Native cultures and spiritual practices have resulted in oversimplifications or distortions with little benefits to the communities under study (Norton & Manson, 1996; Young, 2001). Because of the limited availability of mental health services in many Native communities, particularly in rural areas or reservations, mental health treatment options often require inpatient treatment in facilities outside of a child or adolescent's home community (Boyd-Ball, 2003). The removal of children and youth for mental health treatment often evokes the history of forced removals of Native children to Indian boarding schools and contributes to the mistrust and resistance in the population to accepting such service options (Boyd-Ball, 2003).

While the mental health research literature has not actively focused on the emotional and mental health effects of historical trauma in African Americans, researchers in the areas of cancer and HIV research have addressed the fear and distrust in health systems among African Americans, as a consequence of historical abuses committed by physicians and researchers since antebellum. These abuses include the well-known 1932 Tuskegee Syphilis Study, in which African American men infected with syphilis were intentionally left untreated, as well as less publicized cases of forced gynecological experiments on slaves and the involuntary sterilizations of African American women in federally funded health care clinics in the 1960s and 1970s (Bonner, 2003; Gamble, 1997). The collective knowledge of these experiences coupled with a history of involuntary migration, slavery, and legal discrimination has conspired to create deep-seated attitudes that can lead to high rates of unmet need and low rates of mental health service utilization among African American families and children. As mental health research with African American and Native American populations shows, the complex socio-historical factors which can shape a population's negative interaction with health and service systems requires substantial consideration on the part of service providers.

The interactions of Latinos and Asian Americans/Pacific Islanders with service systems must also be investigated in order to decrease negative experiences and

limited service use, especially among Asian Americans and Latinos who speak little to no English or those with limited knowledge of U.S. service systems. Although segments of the U.S. Latino and Asian and Pacific Islander populations predate the establishment of this nation, the overall history of these populations is generally viewed as having been shaped by migration to this country. Further, these broad cultural groupings each contain populations from numerous home countries, many of whom speak diverse languages – as is the case with Asian Americans, in particular. The reasons for migration to this country are also diverse, including individuals who have migrated to this country as refugees under threat of persecution, as a consequence of war, or famine/food insecurity. The migration process itself can cause a number of stressors manifested throughout the continuum of adaptation and acculturation to this country with mental health implications (Falicov, 1998; Leon & Dziegielewski, 1999; Pumariega, Rothe, & Pumariega, 2005). These stressors may be further compounded for immigrants who enter this country without documentation after dangerous journeys and/or victimization at the hands of smugglers or others facilitating migration (Pumariega, Rothe, & Pumariega, 2005). For refugee populations, the migrant experience may include trauma as a result of war and other disasters in the home country and/or detention (Pumariega, Rothe, & Pumariega, 2005). Knowledge of such historical contexts, gives providers vital information for designing more effective and responsive interventions to address emotional and mental health needs within populations with varying levels of acculturation and degrees of English language acquisition.

In addition to understanding the socio-historical context of the underserved populations targeted in this study, providers must make the effort to understand particular cultural characteristics that can shape the way particular communities and families address mental health issues and needs. Chapters 2 through 5 outline in detail the important cultural and linguistic characteristics that mental health service providers should consider in developing strategies for each of the populations highlighted in this monograph. One prime characteristic related to each of the study populations is the high levels of unmet need compared to rates for Whites (Cauce et al., 2002; Ringel & Sturm, 2001; Yeh et al, 2003). These rates of unmet need are also prevalent in children and youth within these populations (U.S. DHHS, 1999). Another characteristic noted for each of the study populations is the diversity of cultural practices, attitudes and beliefs found within each. In addition to the diversity of Latinos and Asian Americans noted earlier, Native Americans and African Americans are also quite heterogeneous and include individuals of diverse ethnic backgrounds with distinct cultural histories and even languages despite the fact that the majority of individuals in both populations are native born and speak English primarily (McKinnon & Bennett, 2005; Ogunwole, 2006). With regard to mental health and illness, individuals within these populations have distinct ways of defining symptoms and conditions, identifying treatments and/or identifying individuals or community groups who can help in case of problems. In addition, stigma associated with mental illness may be quite strong, and as is the case with Asian Americans, may result in a collective sense of shame for a family or “loss of face” (Gong, Gage, & Tacara, 2003; Kramer, Kwong, Lee, & Chung, 2002; Sue, 1994).

Knowledge of historical context provides vital information for designing more effective and responsive interventions.

A total of 17 articles reviewed for this study presented or recommended specific strategies for increasing accessibility, availability, and/or utilization of mental health services.

While all four of the populations highlighted in this monograph show growth rates that exceed those of the White population, Latinos and Asian Americans comprise the fastest growing populations in the country. Latino and Asian American populations increased by 13 percent and 12.5 percent, respectively, from 2000 and 2003, and these growth rates exceed the rate for the general population in this country (Hendricks, 2004). Such widespread changes in the makeup of our national population require understanding on the part of providers in order to develop strategies that will increase accessibility and utilization of available mental health services and avoid increasing disparities.

Research Based Evidence: Direct Service Strategies that Enhance Organizational Cultural Competence

This study identified a number of direct service strategies that were shown to enhance or increase organizational cultural competence and more effectively serve the targeted racial/ethnic groups in this monograph. These broad strategies are highlighted in Table 5, along with their unique application in each targeted population, as presented in Chapters 2-5. The studies reviewed in this monograph presented a variety of research focus areas, including measuring the impacts of specific direct service practices, interventions, or treatments and rates of service utilization and unmet need. The specific strategies presented in Table 5 (under the “Racial/Ethnic Populations” heading) represent practices or interventions that were tested with one or more populations or direct service practices that were recommended as a result of studies identifying variables associated with rates of need, service use, symptom prevalence and/or cultural responsiveness of providers. A total of 17 articles presented or recommended specific strategies for increasing service accessibility, availability, and/or utilization and serve as the source articles for Table 5.

A total of nine broad strategies were recommended by studies reviewed for this monograph. Four of these were related to service access, four were related to service availability, and one was related to service utilization. Only two of these strategies, incorporating family and community supports and using cultural and spiritual resources, were recommended in more than one direct service domain. Examples of unique application of these strategies were identified as being effective in increasing service accessibility and availability for Native Americans and African Americans, in particular. As Table 5 shows, strategies recommended for one particular population are often not recommended for another and some strategies appear to be associated more with one population than the others. This variation is most likely caused by the small number of articles that were found to make explicit strategy recommendations, as well as the limited study foci associated with particular populations (e.g., more articles on Native Americans focused on availability rather than access or utilization). The lack of strategies identified for a particular population should not be taken to indicate that these strategies are not effective with this population. Rather, it more likely indicates that research has not been conducted to measure the degree to which a particular strategy and its unique application is effective with the population in question.

The importance of cultural preferences and the influence these have on the

Table 5
Examples of Direct Service Strategies

Direct Service Domains	Racial/Ethnic Populations			
	African American	Asian and Pacific Islander	Latino	Native American
Access				
Engagement and Outreach	Telephone and first interview intervention shown to increase number of sessions attended (McKay et al., 1998)		Telephone and first interview intervention shown to increase number of sessions attended (McKay et al., 1998)	
	Training staff in intensive engagement found to influence initial engagement and retention rates (McKay et al., 1998)		Training staff in intensive engagement found to influence initial engagement and retention rates (McKay et al., 1998)	
	Providers need to take more time with families to allay consumer fears or concerns (McMiller & Weisz, 1996)		Providers need to take more time with families to allay consumer fears or concerns (McMiller & Weisz, 1996)	
			Create public health campaigns to help caregivers understand children's need for services (Alegría et al., 2004)	
			Target outreach and education to young Latina women highlighting identification of symptoms and positive effects of treatment (Alviderez, 1999)	
Understanding Help Seeking Behaviors		Cultural-specific variables are associated with willingness to seek or recommend mental health treatment to others (Barry & Grilo, 2002)		
		Over 75% of Filipinos sampled did not access formal services but instead relied on an informal system (Gong et al., 2003)		
Incorporating family and community supports				Involve extended kin networks, traditional ceremonies, language programs, and community organizations to increase access to available supports (Novins et al., 2004)
Using cultural and spiritual resources				Develop strategies for incorporating traditional values and resources in mental health interventions (Allen et al., 2004)

Direct Service Domains	Racial/Ethnic Populations			
	African American	Asian and Pacific Islander	Latino	Native American
<i>Availability</i>				
Ethnic specific services and ethnic match	Ethnic match was linked to decreased dropout, increased length of treatment, and higher functioning scores upon treatment completion (Yeh et al., 2004)	Ethnic match was linked to decreased dropout, increased length of treatment, and higher functioning scores upon treatment completion (Yeh et al., 2004)	Ethnic match was linked to decreased dropout, increased length of treatment, and higher functioning scores upon treatment completion (Yeh et al., 2004)	
		Ethnic match shown to increase service use among Southeast Asians of all ages (Ying & Hu, 1994)	Ethnic match shown to improve clinical outcomes for Latino adolescents with mood disorders (Gamst et al., 2004; Yeh et al., 1994)	
		Ethnic match shown to increase utilization of services and length of treatment among API consumers of all ages (Lau & Zane, 2000)		
Using cultural and spiritual resources	Incorporating Kwanzaa principles in program resulted in significant emotional improvement, academic improvement, and healing (Gregory & Harper, 2001; Gregory & Phillips, 1997)			Need to develop intake procedures that work to increase trust and solicit consumer requests for traditional practices (Yurkovich et al., 2002)
Incorporating family and community supports				Including extended family and collective ceremonies help make existing services more culturally responsive (Boyd-Ball, 2003)
Training and personnel support				Significant improvement in attitudes found among child welfare personnel after increased cultural sensitivity training and ongoing support (Bending, 1997)
<i>Utilization</i>				
Improving Diagnoses and Referrals	Need to ensure children in need are appropriately identified and service referrals are communicated in culturally acceptable and supportive ways to family members (Yeh et al., 2002)	Need to ensure children in need are appropriately identified and service referrals are communicated in culturally acceptable and supportive ways to family members (Yeh et al., 2002)	Need to ensure children in need are appropriately identified and service referrals are communicated in culturally acceptable and supportive ways to family members (Yeh et al., 2002)	

use of mental health services is evident when making cross-ethnic comparisons of issues and strategies. Although the number of articles reviewed for this monograph is quite limited, a key difference was noted with regard to the help-seeking behaviors of API parents versus those of African American and Latino parents. According to Abe-Kim, Takeuchi, & Hwang (2002), Chinese American families that were experiencing greater stress were more likely to seek formal mental health services and appeared to use informal services when they did not know about available services. Conversely, McKay, Pennington, Lynn, and McCadam (2001) found that attendance rates were lower for African American and Latino families who had higher levels of family stress. In addition, they found that African American and Latino families were more likely to approach informal supports, such as extended family or community networks, when they identified mental health needs. Such a striking difference in findings, despite their lack of generalizability to larger populations, underscore the degree to which culture can shape help-seeking behaviors and the overall use of mental health services by particular communities. Such evidence, though limited, also highlights the need for providers to identify and understand the degree to which their service delivery efforts accommodate such cultural preferences for particular target communities.

Research evidence highlights the need for providers to identify and understand the degree to which their service delivery efforts accommodate cultural preferences for particular target communities.

Access to Services

Engagement and outreach strategies were most often recommended to increase access among African Americans and Latinos. Findings from research that included African American and Latino youth in the study sample indicate that continued engagement with family members following an initial contact with a provider can increase the number of sessions attended by youth needing services (McKay, Stoewe, McCadam, & Gonzales, 1998). Due to these findings, McKay et al. (1998) recommend providing staff training on intensive family engagement processes and skills to increase the use of services among urban minority youth with mental health needs. McMiller & Weisz (1996) also recommend that providers take more time with parents and families of African American and Latino youth in need to address fears or concerns associated with the mental health service system. Another outreach strategy recommended with Latinos calls for the implementation of targeting outreach and public education that highlights the positive effects of services and treatments for children and young Latinas, as well as help in identifying mental health symptoms (Alegria, Canino, Lai, Ramirez, Chavez, Rusch, & Shrout, 2004; Alvidrez, 1999).

Strategies associated with help-seeking behaviors were recommended for working with Asian American/Pacific Islander populations (Uba, 1994; Zhang, Snowden, & Sue, 1998). Because studies with Asians Americans and Pacific Islanders often focused on the low levels of help-seeking associated with these populations, the strategies recommended relate to increasing help-seeking rates through targeting of informal community networks and individuals who have been identified as being more likely to recommend the use of mental health services (Barry & Grilo, 2002; Gong et al., 2003). Finally, direct service strategies that incorporate family and community supports and support the use of cultural and spiritual resources were outlined for Native Americans. Studies call for increased community

Adapting to the cultural and linguistic characteristics of the community, including ethnic specific services, and ethnic matching with personnel, are important strategies.

and family involvement in service and treatment delivery for Native American children and youth through programs that make use of traditional ceremonies and beliefs in order to facilitate the use of available services (Allen, LeMaster, & Deters, 2004; Novins, LeMaster, Jumper Thurman, & Plested, 2004).

Availability of Services

The array of services that are available is a key issue in communities and neighborhoods where racially/ethnically diverse families live. Lack of access to specialty services resulting in frequent referrals to juvenile justice or child welfare, or reliance on crisis or emergency services are of particular concern. Adapting to the cultural and linguistic characteristics of the community, including ethnic specific services, and ethnic matching with personnel, are important strategies recommended for use with African Americans, Asian Americans/Pacific Islanders, and Latinos. The use of ethnically matched service providers was found to increase rates of treatment attendance, improvements in functioning and clinical outcomes, and overall service utilization in these populations (Gamst, Dana, Der-Karabetian, & Kramer, 2004; Lau & Zane, 2000; Yeh, Takeuchi, & Sue, 1994; Ying & Hu, 1994). The use of cultural and spiritual resources in service delivery was shown to be particularly effective among African American youths attending a treatment program that incorporates the seven principles of Kwanzaa: unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith. African American youth completing the program showed significant emotional and academic improvements, as well as demonstrated healing (Gregory & Harper, 2001; Gregory & Phillips, 1997). In relating this strategy to Native Americans, Yurkovich, Clairmont, and Grandbois (2002) recommend the development of intake procedures that allow for trust to develop between providers and the children and families seeking services, as well as solicit preferences for use of traditional practices in treatment programs. Yurkovich et al. (2002) also note that use of cultural and spiritual resources should be directed by the family whenever possible, even in cases where providers and consumers are ethnically matched. When used in treatment programs that also incorporate extended family networks, Native American practices have been found to make existing services more culturally responsive (Boyd-Ball, 2003). The use of cultural sensitivity training and ongoing support was also recommended for providers working with Native Americans to improve provider attitudes in their work with Native populations.

Utilization of Services

Finally, strategies that focus on retention of racially/ethnically diverse populations in services need further development. Some examples of retention strategies provided in this monograph that are linked to improved functional and clinical outcomes, as well as satisfaction with services. Additional work is needed to develop and test strategies that are effective in retaining racially/ethnically diverse populations in services as long as they are needed, and to determine the degree to which positive outcomes are maintained after discharge maintaining positive outcomes after discharge. For example, more studies are needed of ethnic specific services such

as the evaluation of the Therapeutic Foster Care (TFC) (Gregory & Harper, 2001) and The Shadow Project (Boyd-Ball, 2003). The research also recommends development of methods for better identification of diverse children's symptoms and mental health needs, as well as more culturally appropriate and supportive communication about them to families (Yeh et al., 2002). Incorporation of such strategies in service delivery may contribute to more appropriate placement and increased participation in services.

Recommendations for Further Research

This review of research conducted with racially/ethnically diverse children and their families points to the need for greater focus on adolescents and children in mental health services research (Gamst et al., 2004; Vega & Lopez, 2001). Within all direct service domains differences may exist for early childhood and middle childhood in comparison to adolescent clients. A few studies have looked at specific child age groups or compared adolescents to children, but additional research is needed that approaches the issues of access, availability and utilization with a consideration for child developmental stages.

Within-Group Differences

There is also a clear need for identification of within-group differences by factors such as country of origin, immigration or refugee experiences, gender, tribal affiliation, and community of residence within the United States (Fisher & Ball, 2003; Hough, Hazen, Soriano, Wood, McCabe, & Yeh, 2002; Jerrell, 1998; Makini, Andrade, Nahulu, Yuen, Yates, McDermott, Danko, Nordquist, Johnson & Waldron, 1996; Sue & Chu, 2003; Takeuchi & Kramer, 2002; U.S. DHHS, 2001). The few studies that have been conducted with some attention to these variations suggest that there are significant differences in population characteristics within groups, as well as in their interactions with mental health services and/or in the outcomes of those services (Alegría, Canino, Rios, Vera, Calderon, Rusch, & Ortega, 2002; Alegría et al., 2004; Beals, Piasecki, Nelson, Jones, Keane, Dauphinais, Red Shirt, Sack, & Manson, 1997; Cuffe, Waller, Addy, McKeown, Jackson, Moloo, & Garrison, 2001; Cummins, Ireland, Resnick, & Blum, 1999; Duclos, Beals, Novins, Martin, Jewett, & Manson, 1998; Gray-Little & Hafdahl, 2000; Jerrell, 1998; Novins, Duclos, Martin, Jewett, & Manson, 1999; Ringel & Sturm, 2001; Szalacha, Erkut, Garcia Coll, Alarcon, Fields, & Ceder, 2003; Wu, Hoven, Bird, Moore, Cohen, Alegría, Dulcan, Goodman, Horwitz, Lichtman, Narrow, Rae, Regier, Roper, & Margaret, 1999; Wu, Hoven, Cohen, Liu, Moore, Tiet, Okezie, Wicks, & Bird, 2001; Yeh, Eastman, & Cheung, 1994; Yeh, Takeuchi, et al., 1994).

One aspect of within group differences is to look at racial/ethnic populations in a variety of geographic locations in order to enhance application of findings to different types of communities (Allen et al., 2004; Chow, Jaffee, & Snowden, 2003; Fisher & Ball, 2003; Pumariaga, Glover, Holzer, & Nguyen, 1998). In most cases, studies are limited to communities where certain researchers have access, which is further limited by the small pool of researchers studying racial/ethnic populations (Alegría et al., 2004; Alegría, Canino, Rios, Vera, Calderon,

This review of research conducted with racially/ethnically diverse children and their families points to the need for greater focus on adolescents and children in mental health services research.

It is important to consider preferences and experiences of the parent or caregiver that may vary by acculturation, gender, or tribal affiliation. This includes how parents interpret symptoms, who they trust to help or provide advice, how they perceive the mental health system, financial resources, and how much stress they are experiencing.

Rusch, & Ortega, 2002; Beals et al., 1997; Gamst et al., 2004; Jerrell, 1998; Maynard, Ehreth, Cox, Peterson, & McGann, 1997; Novins et al., 1999; Wu et al., 2001; Yeh, Eastman et al., 1994; Yeh, Takeuchi et al., 1994). The limited number of geographic locations where studies are conducted also limits understanding of within-group variations (Manoleas, Organista, Negron-Velasquez, & McCormick, 2000).

Also important to understanding within-group variation is consideration of acculturation, experiences with historical trauma, age, and gender in identifying coping mechanisms and informal networks, beliefs about mental health, help-seeking patterns, and ethnic match preferences (Broman, 1996; Brome, Owens, Allen, & Vevaina, 2000; Gamst et al., 2004; Kellerman, 2001; McCabe, Yeh, Hough, Landsverk, Hurlburt, Culver, & Reynolds, 1999; Whitbeck, Adams, Hoyt, & Chen, 2004; Zimmerman, Ramirez-Valles, Washienko, Walter, & Dyer, 1996). Differences have been documented in the level of mistrust of the formal health system, reporting of institutional and social discrimination, and preference for family, religious, or ethnic mental health providers during help seeking (Broman, 1996; Cuffe et al., 1995; McMiller & Weiz, 1996; Saegart, 1989; Snowden, 1998; Sue, & Chu, 2003; Taylor, & Chatters, 1991; Yeh et al., 2002). Differences in use of specific types of services have also been found to be affected by age, gender and acculturation level, in addition to race/ethnicity (Alegría et al., 2002; Hurlburt, Leslie, Landsverk, Barth, Burns, Gibbons, Slymen, & Zhang, 2004; Jerrell, 1998; Maynard et al., 1997; Pumariega et al., 1998; Yeh et al., 2002). It is also important to consider preferences and experiences of the parent or caregiver that may vary by acculturation, gender, or tribal affiliation. This includes how parents interpret symptoms, who they trust to help or provide advice, how they perceive the mental health system, financial resources, and how much stress they are experiencing (Alegría et al., 2004; McKay et al., 2001; Novins et al., 2004; Yurkovich et al., 2002). Research that increases understanding of help-seeking patterns and service preferences within groups will assist in designing more effective early intervention and engagement strategies, as well as having an impact on retention and utilization rates (Abe-Kim et al., 2002; Bui & Takeuchi, 1992; Cheung & Snowden, 1990; Gong et al., 2003; Leong, 1994; Lin & Cheung, 1999; Kung, 2004; Matsuoka, Breaux, & Ryujin, 1997; Sue & Sue, 1990; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Yeh et al., 2002; Zhang & Snowden, 1999; Zhanget al., 1998).

Research Approaches and Methods

Researchers are urged to consider cultural differences and negative past experiences with research when choosing elicitation approaches and methods. Self-report of factors such as needs, barriers, utilization, and satisfaction with services are impacted by cultural beliefs and values such as respect for authority, cultural thresholds for symptomatology, as well as understanding of the service system in the United States (McCabe et al., 1999; Yeh et al., 2003). It is recommended that studies specify whether culturally compatible diagnostic instruments or impairment criteria were used (Bird, Canino, Rubio-Stipeck, Gould, Ribera, Sesman, Woodbury, M., Huertas-Goldman, S., Pagan, A., Sanchez-Lacay, A., & Moscoso, M., 1988; Shaffer, Fisher, Dulcan, Davies, Piacentini, Schwab-Stone,

Lahey, Bourdon, Jensen, Bird, Canino, & Regier, 1996; Shaffer, Gould, Brasic, Ambrosini, Bird, & Aluwahlia, 1983; Vega & Lopez, 2001). Also recommended are elicitation instruments that are developed in the languages of racial/ethnic groups within the communities to ensure accurate representation (Alegría et al., 2002; Alegría et al., 2004; Hough et al., 2002; Wu et al., 1999). In addition, collection of data must include procedures that ensure reliability of reports by racially/ethnically diverse parents and children (Canino, Shrout, Alegría, Rubio-Stipec, Chavez, Ribera, Bravo, Bauermeister, Fabregas, Horwitz, & Martinez-Taboas, 2002). Finally, research approaches need to be developed that promote community collaboration throughout the research process (Baldwin, 1999; Beauvais, 1999; Fisher & Ball, 2003; LaFromboise & Howard-Pitney, 1994)

An additional recommendation is for further study of ways in which instruments collect and report information about ethnicity and race. Little is known about preferences for self-reporting, or how people think about reporting their ethnicity. In addition, many studies rely on secondary data that does not allow for additional analysis of ethnicity/race identification. The lack of consistency in naming groups that were included in studies reviewed (e.g. Latino, Hispanic, White, Non-Hispanic White, Black, African American, or Asian American, Asian Pacific Islander, Native American, and American Indian) adds a great deal of ambiguity about the applicability of results even within a commonly recognized racial/ethnic group. Further study will assist in understanding how people group themselves within communities and how mental health research applies to them.

System and Community Contexts

The final recommendation for future research is to better explain the direct service process by identifying and describing the influence of community and system factors. This might include system-level access barriers such as cost and location of services, insurance coverage, quality of services, opportunities for racial or ethnic match, and the scarcity of services within certain neighborhoods or communities (Allen et al., 2004; Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2000; Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2001; Johnson & Cameron, 2001; Pumariega et al., 1998; Wu et al., 2001). Research on prevalence rates, unmet needs, and utilization patterns also needs to consider the use of alternative or informal services, such as spiritual and family resources, and perceived barriers as well as the impact of systemic discrimination on formal service use (Novins et al., 1999; Yeh et al., 2003). Also needing further explanation is the impact of state policies and health care market characteristics on access to services at the local level (Sturm, Ringel, & Andreyeva, 2003). Studies including these factors would improve understanding of the ways in which social structures impact utilization of services and could lead to more appropriate adaptations within specific community contexts.

It is hoped that application of these recommendations for research and practice will contribute to decreasing disparities. As the conceptual model suggests, focusing on compatible, interrelated components in an organization, including infrastructure and direct service domains, and characteristics of the populations in the community will assist in developing organizational cultural competence.

Researchers are urged to consider cultural differences and negative past experiences with research when choosing elicitation approaches and methods.

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Appendix A: African American

Appendix A: Summary of Strategies—African American

Direct Service Domain	Population Characteristics-Organizational Compatibility Issues	Direct Service Strategies
Access	Diversity within the population, including socioeconomic status, geographic location, and family makeup	<ul style="list-style-type: none"> Investigate and tailor mental health services to meet the needs of each community or population group served Promote an environment that appreciates diversity at the point of entry Address transportation needs and flexible scheduling Develop flexibility in payment structures Promote diversity in staff composition, including state or region of origin and socioeconomic background
	Experiences of institutional discrimination, marginalization and bias	<ul style="list-style-type: none"> Self-assess for bias and discrimination in procedures and actions Outreach to extended family, friends, and religious communities Train staff in specific engagement strategies for a positive intake experience Allow for time to develop trust during interactions with families
	Overrepresentation in involuntary referrals, emergency, and punitive services.	<ul style="list-style-type: none"> Develop community access points through schools, recreational, or religious organizations Link youths/families with someone they feel comfortable talking to about what they are experiencing
	Lack of information about symptoms and available services for different levels of need.	<ul style="list-style-type: none"> Outreach to families and informal supports with information about needs recognition and the array of services and treatments available to meet different levels of need Create linkages between parents, schools, informal, and formal mental health services
Availability	African American churches provide many mental health services and social services.	<ul style="list-style-type: none"> Create linkages with churches and religious groups to smooth transitions between formal and informal services. Integrate spiritual resources into in organizational structures, values, and direct service interventions.
	Preferences for racial/ethnic-matching may differ for African American children, adolescents and adults.	<ul style="list-style-type: none"> Assess the child and family's preference for race/ethnic match and conduct on-going assessment of effectiveness of the match Ensure cultural competency of all providers Promote the development, growth, and sustainability of race/ethnic specific services and providers
Utilization	African Americans have higher rates of early termination of services and shorter treatment lengths.	<ul style="list-style-type: none"> Provide training and guidance to staff emphasizing initial engagement with families, including strategies to decrease stress, accommodate the time requirements placed on a single parent, and avoid judgments about child discipline Identify gaps in the types or timing of services that are utilized by developing intake procedures that assess for them without bias Gather and use consumer input to design the array of service types and improve outreach, engagement, and retention
	Dropout rates for African American families are higher than for White families and continually increased with each ongoing week in treatment.	<ul style="list-style-type: none"> Identify and eliminate biases in the referral, diagnoses, and treatment processes Provide needed services in the child and/or family's natural settings Distinguish between patterns of referral bias and patterns of help seeking that affect types and intensity of services received Reduce system-level barriers, such as cost and location of services, limited options for ethnic match, or a lack of culturally competent providers Promote development of family-therapist trust by connecting to informal support systems, incorporating the family's religious beliefs, and conducting home visits Collect consumer input about experiences with services on an on-going basis

Appendix B: Asian and Pacific Islander

Appendix B: Summary of Strategies—Asian and Pacific Islander

Direct Service Domain	Population Characteristics-Organizational Compatibility Issues	Direct Service Strategies
Access	Diversity of the population , including socioeconomic status, acculturation level, and nation of origin impacts beliefs about mental health and help-seeking.	<ul style="list-style-type: none"> • Address perceived barriers to care and beliefs about mental health of parents and children • Develop intensive outreach to API families to increase needs recognition and comfort with seeking help • Increase API family and community knowledge regarding the positive benefits of mental health services and develop strategies to facilitate voluntary and earlier entrance into services • Focus on outreach efforts that increase family knowledge of the formal mental health system • Assess level of acculturation and linguistic preference of parents and children • Link with informal systems and interpreters
	Fear of loss of face may be experienced by API adults and children.	
	Varying linguistic capacities and interpretation needs that impact outreach and engagement	
	View formal providers as a last resort, relying instead on families and social networks, and entering services only when referred by criminal justice or social services	
Availability	Families often enter services late in the help-seeking process and are experiencing high levels of stress and conflict at the time	<ul style="list-style-type: none"> • Provide quick scheduling of initial appointment and immediate care with a language-match prescreening interviewer who also serves as the intake therapist • Determine preference for ethnic and gender match and assess outcomes and satisfaction on an individual and family basis • If preferred, match by race/ethnicity, language, and specific area of origin between therapist and family, including matching on immigration/refugee experiences if preferred • Track attendance, treatment lengths, and return rates for API children and parents using ethnic matched, ethnic specific, and mainstream providers • Promote professional development of bi-lingual and bicultural personnel to increase the pool of providers • Promote and develop ethnic specific interventions in communities where API families and youth live
	Children, adolescents and parents variously prefer ethnic and gender matched providers.	
	Asian females and children attending ethnic specific programs experience better outcomes.	
	Ethnic specific providers and mental health professionals are scarce.	
Utilization	There are differences in utilization rates and patterns by geographic location and sub-groups of APIs.	<ul style="list-style-type: none"> • Assess the unique pathways into care of API youth and families in the community • Include in cultural competency training information about typical utilization patterns and strategies for improving them • Develop and implement cultural adaptations to assessment through consulting with cultural experts, tailoring instruments, and training staff

Appendix C: Latino

Appendix C: Summary of Strategies—Latino

Direct Service Domain	Population Characteristics-Organizational Compatibility Issues	Direct Service Strategies
Access	Parents, children, and adolescents have beliefs about help-seeking based on culture and experience, which result in fear and distrust of formal providers.	<ul style="list-style-type: none"> Identify factors that hinder parents from bringing their children to needed services, such as: <ul style="list-style-type: none"> Fear that the child/adolescent might be removed from the home or hospitalized A lack of information about health insurance coverage of mental health services Hesitancy of involving those outside the family Beliefs about coping with problems and causes of mental illness Parents feeling a lack of efficacy in dealing with child's problems Past experiences with discrimination or misunderstanding due to cultural or linguistic differences
	Facilitate help-seeking through education and information	<ul style="list-style-type: none"> Educate parents and the community about the need for early intervention and use of services when symptoms are less severe (increase understanding of the link between symptoms and child functioning) Educate families about available services and treatments Public health education campaigns to make link between impairment and need for mental health care, distinguish the need for professional help from help that can be provided by informal sources
	Enhance community outreach	<ul style="list-style-type: none"> Incorporate family and community members in addressing outreach efforts and decision-making about seeking services Expand outreach efforts to include direct contact with community leaders and families rather than outreach through other professionals or agencies in the community Develop public health education campaigns that make the link between impairment and need for mental health care and distinguish the need for professional help from help that can be provided by informal sources Periodically assess whether outreach has reached intended populations and resulted in improved access and utilization Obtain consumer input to develop innovative service delivery options, outreach efforts, and alternative service locations
	Invest in the engagement process	<ul style="list-style-type: none"> Use bilingual/bicultural engagement practices at multiple points of contact, such as telephone calls between an initial call and the intake appointment and before a treatment session. Involve families in assessment and intervention processes immediately after initial contact Help families identify and eliminate barriers to treatment during the engagement process Address hesitancy of parents who have difficulty disciplining their child in attending initial intake or continuing services for their child Implement training and supervision on engagement practices emphasizing taking the time needed to develop trust Tailor intake procedures and interventions to address specific barriers identified through consumer input
Availability	Expand the options for ethnic-specific services	<ul style="list-style-type: none"> Develop culturally/linguistically appropriate assessments and referral procedures Increase availability of bicultural and bilingual mental health services and supports Refer to ethnic specific providers based on assessed need or preference of child or family Identify strategies or approaches used by ethnic specific providers that might be used effectively by mainstream providers Develop strategies for addressing the shortage of Latino providers
	Address regional disparities in availability of services	<ul style="list-style-type: none"> Develop strategies to address the shortage of Latino providers in low income Latino communities Increase acceptance of Medicaid among providers in high poverty and high immigration areas Increase transportation and scheduling options
	Increase cultural/linguistic appropriateness of procedures and resources	<ul style="list-style-type: none"> Increase availability of bicultural and bilingual mental health staff, materials, and other supports Match services to Latino families' needs and communicate caring and competence Develop culturally/linguistically appropriate assessments and referral procedures

Direct Service Domain	Population Characteristics-Organizational Compatibility Issues	Direct Service Strategies
Utilization	Address both cultural and socioeconomic issues in service utilization	<ul style="list-style-type: none"> • Develop interventions that target entire Latino families • Address cultural differences in discipline • Assess levels of family stress and social support • Increase understanding of reasons for service preferences and satisfaction with services • Reduce stigma associated with Latinos receiving mental health services • Develop strategies for identifying and decreasing discrimination within provider agencies • Assess the impact of cultural thresholds for symptomatology, use of alternative mental health services, and different beliefs about mental health/mental illness among Latino families • Assess the community's demographic composition, availability of services, and stigmas related to mental health • Reduce the influence of poverty and location of residence on access to and availability of financing and quality service options
	Adapt assessment and referral procedures to meet the needs of Latino families where they are	<ul style="list-style-type: none"> • Enhance mental health services provided by primary care physicians • Develop strategies to increase the use of specialty care at earlier stages of need among Latinos • Develop a variety of payment options in high poverty communities • Develop strategies to ensure Latino children receive specialty mental health services at sufficient frequency and intensity and at earlier ages • Address the disparities in the way Latino children in high poverty environments are referred for services (criminal justice, schools, emergency rooms) • Develop strategies to enhance mental health services provided through educational systems • Develop strategies to address suicide ideation, depression, anxiety symptoms, and school drop out • Develop financing strategies to cover specialty care that is not covered by insurance • Increase services provided to pre-school aged children • Supplement outpatient services with other needed services
	Improve methods for identifying unmet need of Latinos in the community	<ul style="list-style-type: none"> • Assess unmet need by aspects of care, such as psychiatric visits and drug therapy • Examine trends in insurance coverage and spending and track recipient characteristics such as age and ethnicity • Develop strategies to match types of services with the level and type of need • Identify regional characteristics that drive disparities in utilization compared to level of need, and develop strategies to address these disparities • Further examine prevalence of specific disorders such as disruptive disorders, and low levels of diagnosis and provision of specialty mental health services for Latino adolescents • Develop strategies to ensure Latino children receive specialty mental health services at sufficient frequency and intensity at earlier ages
	Assess rates of utilization for Latinos compared to other groups in the community	<ul style="list-style-type: none"> • Examine utilization rates by types of services and diagnoses for all populations that should be served • Consider differences in utilization by gender and age of Latino children/adolescents • Examine Latino utilization across service sectors by comparison with prevalence rates • Examine levels of utilization by level of mother's education and other indicators of socioeconomic status when examining Latino utilization rates • Ensure studies of service utilization rates use Spanish-language acculturation and diagnostic instruments for appropriate inclusion of Spanish monolingual and bicultural children and families and appropriate interpretation of results

Appendix D: Native American

Appendix B: Summary of Strategies—Native American

Direct Service Domain	Population Characteristics-Organizational Compatibility Issues	Direct Service Strategies
Access	Perceived loss related to historical trauma impacts help-seeking	<ul style="list-style-type: none"> • Increase knowledge about services and address the wariness of seeking mental health assistance • Incorporate traditional spiritual and cultural practices into family-based services that address mental health
	Community collaboration is important in identifying needs and barriers	<ul style="list-style-type: none"> • Assess and address infrastructure barriers such as limited services in the community, lack of transportation, lack of telephones, lack of payment options, and scheduling problems
	3) It is important to not single out Native American children with emotional/behavioral difficulties	<ul style="list-style-type: none"> • Target mental health interventions in schools to entire classrooms rather than individual children • Incorporate adolescents from the community in conducting needs assessments and avoid spotlighting those with mental health issues
Availability	Link to cultural practices in all aspects of care:	<ul style="list-style-type: none"> • Incorporate important Native American ceremonies into social, health, and mental health interventions and involve families along with children and youth • Develop prevention and early intervention efforts that incorporate the unique cultural and historical characteristics of particular communities • Involve families in developing the treatment plan using culturally responsive techniques to elicit self-assessment • Include strategies for re-entry into the home, such as a Welcome Home Ceremony that builds family and community support for the child • Train Native as well as non-Native providers to accept cultural differences and ask for ways to incorporate the client's traditional practices and activities into treatment rather than rely completely upon ethnic match to ensure cultural appropriateness • Incorporate a thorough cultural assessment during intake to develop trust and respect between provider and patient and make the patient central to his/her healing.
	Provide training and support for staff to address community issues sensitively and effectively	<ul style="list-style-type: none"> • Provide trained follow-up workers from the community to conduct parent and child monitoring, reduce peer clustering, maximize family engagement, and respond to the effects of historical trauma • Conduct culturally responsive research and evaluation that can verify effectiveness of interventions • Develop strategies and training for culturally competent implementation of the Indian Child Welfare Act of 1978 (ICWA) for both state and tribal workers • Streamline bureaucratic requirements that impact implementation of ICWA standards in a culturally sensitive manner
	Enhance linkages with policy and funding sources to better support culture-specific strategies	<ul style="list-style-type: none"> • Create linkages at administrative, state, and tribal levels • Provide resources for time and/or billing procedures that allow for enhanced intake procedures

Direct Service Domain	Population Characteristics-Organizational Compatibility Issues	Direct Service Strategies
Utilization	Develop culturally appropriate ways to assess unmet need and utilization rates	<ul style="list-style-type: none"> • Assess the local utilization rates for outpatient and more restrictive placements for Native American children and adolescents in the community • Develop mental health screening methods for key stakeholders such as the juvenile justice system to increase evaluation and treatment options
	Learn about family and child preferences for treatment	<ul style="list-style-type: none"> • Identify and promote protective factors such as family caring, connectedness to school, and particular skills or competencies • Develop an understanding of Native American preferences for types of treatment and medication use within the local community • Involve more Native American youth in prevention and early intervention efforts to reduce alcohol and mental health problems • Train providers to accept cultural differences and incorporate the client’s traditional practices and activities into treatment • Use a cultural assessment to develop trust and respect between provider and patient • Make the patient central to his/her healing • Identify and promote protective factors such as family caring, connectedness to school, and particular skills or competencies