NAMI
National Alliance on Mental Illness

An Overview of Multicultural Issues in Children's Mental Health

NAMI Multicultural Action Center

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Introduction

Disparities in for diverse communities are well documented. Several studies and landmark reports have systematically highlighted the barriers to treatment communities of color face and the lack of quality of care they receive once they access care. This document will explore and summarize disparities in access and quality issues in children's mental health for four racial- and ethnic-group: African American, Asian American, Latino/Hispanic American, and American Indian/Alaska Native. We realize that these designations fail to capture the diversity and richness within each group in terms of country of origin; migration history to the United States, whether freely made or forced; the resettlement process; and a range of current experiences of discrimination, socioeconomic status, and ethnic identity across generations. All of these differences have important implications in the real or perceived stigma, barriers, recognition, and treatment of serious emotional or mental problems.

To emphasize the limitation of using a broad racial/ethnic designation, we use *African American* to denote persons of African descent, which now include refugees and immigrants from Sudan, Nigeria, and other African countries. The generic term *Asian American* refers to persons with historical ties to China, Hong Kong, Taiwan, Korea, Vietnam, Cambodia, Laos, Philippines, Malaysia, India, or other Asian countries, as well as native Hawaiian and Pacific Islander persons. The term *Latino/Hispanic* encompasses multiple Spanish-speaking groups including Mexican, Puerto Rican, and Cuban. *Native American* captures the many tribes of American Indians as well as Alaska natives. These four designations parallel those used by the U.S. Office of Management and Budget and the Bureau of the Census, and they are often the categories used in reports and research studies.

Cultural Competence in Mental Health Services for Children and Adolescents

Over the last three decades, slow progress has been made in the field of mental health for children and adolescents of color. The publication of Jane Knitzer's *Unclaimed Children* (1986) made clear that children most in need of mental health services were not receiving service or were inappropriately served. The de facto mental health system for children and adolescents was fragmented with diffuse responsibilities for a child's well-being spread across multiple agencies with different mission statements. For children of color, the problem was compounded by cultural and language barriers to care.

The movement toward more culturally competent mental health service systems can be traced back to 1988, when the National Institute of Mental Health's (NIMH's) Child and Adolescent Service System Program (CASSP) established a Minority Initiative Resource Committee. During committee meetings, it was apparent that a new framework for dealing with diversity was needed. A subcommittee was formed; and their work, begun in May 1988, resulted in a monograph entitled *Towards A Culturally Competent System of Care* (Cross et al., 1989). This was a seminal effort because the proposed model does not set blame for racial/ethnic disparities or imply that a racial/ethnic quota is needed to fix the disparities.

The model simply made the assumption that cultural competence, like any skill, can be learned. Cross et al. explained the terms *culture* and *competence* as follows:

> The word culture is used because it implies the integrated patterns of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. The word competence is used because it implies having the capacity to function in a particular way: the capacity to function within the context of culturally integrated patterns of human behavior defined by a group. Being competent in cross–cultural functioning means learning new patterns of behavior and effectively applying them in the appropriate settings.

The cultural competence continuum contains six markers with *Cultural Destructiveness* at the bottom end and *Cultural Proficiency* at the top. The essential point is that few are at the bottom of the scale at *Cultural Destructiveness* and few reach the top at *Cultural Proficiency*, but movement along the continuum towards cultural competence is possible. Cultural competence is defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al., 1989; Isaacs & Benjamin, 1991). Operationally defined, *cultural competence* is "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes" (Davis, 1997).

Cultural Competence Continuum
(Cross et al., 1989)
1. Cultural Destructiveness
2. Cultural Incapacity
3. Cultural Blindness
4. Cultural Pre-competence
5. Cultural Competence
6. Cultural Proficiency

Two monographs followed the Cross et al. initial publication. The monograph, *Towards A Culturally Competent System of Care: Programs Which Utilize Culturally Competent Principles: Volume II* (Issacs & Benjamin, 1991), gives examples of programs that applied the principles of cultural competence in serving children and families of color. The last volume of the three-volume series, *Towards a Culturally Competent System of Care: The State of the States: Responses to Cultural Competence and Diversity in Child Mental Health: Volume III* (Shockley, 1998), examines the development and implementation of cultural competence within state and local child mental health systems over a five-year period. It reviews shifts in policy, procedure, and administrative structures in addressing federal funding mandates in the area of cultural competence and their relationship to service delivery goals and outcomes.

Systems of Care Movement

The systems of care movement grew from the realization that the de facto mental health system for children with serious emotional disturbance was fragmented and basically broken. As observed in the President's *New Commission Report*, "no agency or system is clearly responsible or accountable for young people with serious emotional disturbances. They are invariably involved with more than one specialized service system, including mental health, special education, child welfare, juvenile justice, substance abuse, and health."

An integrated system of care is needed. The guiding principles for systems of care for children with serious emotional disturbance and their families were first articulated by Stroul and Friedman (1986). These principles dictate that systems of care be child centered, family focused, community based, and culturally competent. The implementation of this vision started with private contributions from the Robert Wood Johnson Foundation and the Annie E. Casey Foundation of more than $30 million to cities, states, and neighborhoods across the country.

In 1992, the Center for Mental Health Services (CMHS) launched the Comprehensive Community Mental Health Services for Children and Their Families Program and in 1993 funded four communities with an initial investment of $5 million. Over the next decade, the program funded more than $749 million to 67 grants across the United States and 25 cooperative agreements. The primary goal of the program was to develop systems of care for children with serious emotional disturbances and their families that were tailored to the unique needs of the population they served.

The funded sites varied from an entire state to inner city neighborhoods, individual counties, regional areas of several counties, and Native American tribes. Together the systems of care in these funded communities served more than 62,000 children and their families. Summaries of best practices and lesson learned from a number of funded sites are presented in volume seven of the *Promising Practices* series. Some of the lessons relevant to providing cross-cultural mental health services for children included the role of family involvement; a continuous path to cultural competence; services coordination across systems of child welfare, juvenile justice, and school; and incorporating systems of care values into managed care goals for greater effectiveness and "humanness" to the overall service delivery system.

Independent evaluations of systems of care were conducted by Macro International, Inc. The evaluation had five components that 1) assess system-level changes, 2) describe the children and families served, 3) determine the impact of systems of care on children's emotional and functional outcomes, 4) estimate the range of services provided and their costs, and 5) compare longitudinally systems of care to the de facto mental health system for children and adolescents. Findings from the national evaluation are presented in a series of annual reports to Congress beginning in 1997, including the currently released report for 2002-2003, with subsequent reports released as approved by the administration. The reports are available on the Web at http://systemsofcare.samhsa.gov/Publications/chpubs.aspx. Major highlights include:

- Nearly half of the children and their families served in grant communities funded in 1997-2000 were minorities, with more than 26% African American children, 11% Latino/Hispanic American children, 10% Native American children, and 20% other race or biracial children.

- The majority (65%) of the families were poor, living at or below federal poverty level. Cross-agency partnership was reflected in referral patterns to system of care services.

- Mental health agencies accounted for only 29.5% of all referrals. School (18.5%), social services (11.9%), court (9.4%) corrections (8.0%), caregivers (8.3%), and other sources (14.5%) including friends, self, residential programs, physical health care agencies, and substance abuse treatment clinics participated in referring children with serious emotional disturbance to system of care services.

- More than 70% of children who entered systems of care had one or more risk factors, with running away (33.8%), previous psychiatric hospitalization (29.4%), physical abuse (27.5%), substance abuse (22.0%), and sexual abuse (21.9%) being the most frequently reported lifetime risks.

- The most common psychiatric diagnoses were ADHD (36.5%), mood disorder (31.8%), oppositional defiant disorder (26.6%), adjustment disorder (12.9%), and conduct disorder (11.7%).

- Posttraumatic stress disorder (PTSD) was reported in 8.6% of the children. A small number of children were diagnosed with mental retardation (3.7%) or learning and related disorder (5.2%).

- Systems of care services were effective in treating children with serious emotional disturbance. About 90% of the children showed improvement or maintained stability in their level of behavioral and emotional symptoms since entering systems of care.

- By 18 months after initial intake, half of the children showed significant improvement in behavioral and emotional symptoms, and only 10.8% had deteriorated.

- Children's functional outcomes also showed improvement. Regular school attendance increased from 77% at intake to 84% at 18 months post intake. School performance as measured by a passing grade of C or better also improved from 60% passing at intake to 72.8% at 18 months post intake.

- Involvement with the justice system in terms of being accused of breaking the law, arrested, convicted of a crime, on probation, or in a detention center or jail also decreased steadily from intake to 18 months post intake.

- The program demonstrated that movement towards a collaborative inter-agency, community-based, family-centered, culturally competent system of care is feasible and

effective in improving the mental health and well-being of children with serious emotional disturbance and their families.

To date, the Comprehensive Community Mental Health Services for Children and Families Program funded 126 grants and cooperative agreements to communities throughout the country (see map). Fifty seven are currently funded, and 67 sites have graduated from the Program. The overall funding since the inception of the program in 1993 is over $1.16 billion and funding has been secured for additional sites for the coming fiscal year. Over 79,000 children from all major racial/ethnic groups have been served through the Program. The creation of the Systems of Care Alumni Network ensures the continual collaboration and sharing of information among graduate and newly funded sites. In addition, the federally sponsored Circles of Care provides funds and technical assistance for Native American communities to support the development of culturally appropriate systems of care models.

Mental Health Services for Children in School

The President's New Freedom Report states that children's emotional and mental problems can have a negative impact on their school performance. The Report recommends that schools play a more prominent role in the early identification of children with mental heatlh treatment needs and provide a link to mental health services. However, information on current mental health services in schools across the country was limited at the time the New Freedom report was released.

To address the lack of data, Foster et al (2005) conducted the first national survey of mental health services in schools. Their findings are in the report, *School Mental Health Services in the United States 2002-2003*. The key-informant, mailed survey drew a representative sample of approximately 83,000 public elementary, middle, and high schools and their associated school districts in the United States. The goals of the survey were to describe the most frequent mental health problems in school; the administrative arrangements for the delivery and coordination of mental health services; the types and qualifications of staff providing mental health services in schools; the issues related to funding, budgeting, and resource allocation; and the use of data-sharing regarding mental health services.

The most common mental health problem reported by schools was "social, interpersonal. or family problems." The second most frequent problem was different for boys and girls. Boys had more externalization problems such as aggression or disruptive behavior; whereas girls had more anxiety and adjustment issues. Most schools (87%) reported all students, not just those in special education, were eligible for mental health services, and 20% of students on average received some type of school-supported mental health services in a school year. Mental health services were provided mostly by school counselors, followed by nurses, school psychologists, and social workers. School nurses spent a third of their time providing mental health services.

Most schools (80%) provided a variety of services, including mental health screening, behavior-management consultation, crisis intervention, individual and group counseling, case

management, and referrals to specialized programs. However, there were barriers to providing mental health services in schools, include inadequate school mental health resources, financial constraints of families, competing priorities for use of funds, and difficulties with transportation. A third of the school districts reported funding for mental health services had decreased, while more than two thirds of districts reported an increase in the need for mental health services. Several school districts reported that a high number of students were not able to access mental health services in the community due to linguistic and insurance barriers; and in these cases, counseling provided by the school was the only service available. Schools with high minority enrollment (51%+ minority students) are more likely to have district-operated mental health clinics than schools with low minority enrollment. Almost half of the school districts used contracts or other formal agreement with community-based individuals or organizations to provide mental health services to students. The most frequently reported community-based provider type was county mental health agencies. In short, the findings shed some light to the ongoing controversy of mental health screening in schools. The majority of schools currently provided assessment for mental health problems. How schools decide which students to assess is not clear. That issue needs to be determined in future surveys.

Mental Health Screening in Schools

At the heart of the current debate on MH screening in schools are concerns related to labeling children, the need for parental consent, and concern that information obtained through screening will be inappropriately used by schools. A few organizations have engaged in campaigns of misinformation about mental health screening programs, claiming that the federal government, through the New Freedom Commission report, is calling for mandatory, universal mental health screening without parental consent. These groups also claim that screening will lead to forcing children to use psychotropic medications. A simple reading of the New Freedom Commission report, and specifically Goal 4, makes clear that these claims are false.

A recent article in the *Journal of School Health* (Weist et al, 2007) discusses the issues related to mental health screening in schools. The authors cited the following barriers to providing mental health screening and services in school:

- insufficient funding
- inadequate training and supervision of staff
- difficulty coordinating a full continuum of prevention and intervention services
- maintenance of quality and empirical support of services
- limited evaluation of outcomes of services to improve programs and contribute to policy improvement
- environmental characteristics (poor office spaces, crowded classrooms)
- frequent changes in personnel (high teacher and administrator turnover)
- distinctive knowledge bases and cultures (education and mental health)
- difficulties in fully engaging families
- academic demands stemming from the No Child Left Behind educational reforms

In addition to addressing those barriers, the authors recommended that communities make the following assessments prior to adopting mental health screening in schools:

- availability of trained staff and other resources to conduct screening
- availability of mental health providers with training in evaluating and treating those children and youth identified by screening
- need for technical assistance in system development for ensuring parental consent and student assent for participation in screening
- selection of age-appropriate screening measures
- logistics, including determining when to do the screening, finding the right confidential space for screening, and providing alternative activities for youth who do not have parental permission for screening
- resolution of liability concerns about confidentiality and information-sharing between schools and collaborating community agencies

However, they failed to mention the need for culturally valid diagnostic or screening tools, protective measures against racial profiling, and culturally competent mental health treatment and services.

Mental Health Services for Children in the Juvenile Justice System

Research has shown there is a higher prevalence of mental disorders among youth in the juvenile justice system than in the general population. For youth in juvenile detention, the prevalence of at least one psychiatric disorder is 66% for boys and 75% for girls (Teplin et al., 2002). Specific learning disabilities and emotional disturbance are the two most common disabilities found in the juvenile justice system (Burrell and Warboys, 2000). Half of the population of youth in the juvenile justice system have emotional disturbance (ED), and one in five has serious emotional disturbance(Rutherford et al. 2002). Attention deficit/hyperactivity disorder (ADHD) is four-to-five times more prevalent in correctional facilities than in schools. Between 20% and 50% of incarcerated youth are estimated to have ADHD (Rutherford et al. 2002).

Minority youth are over-represented in the juvenile justice system. Minority youth accounted for 38% of the U.S. juvenile population and 61% of juveniles in custody in 2003. In addition, minorities accounted for 63% of juveniles committed to public facilities nationwide – a proportion nearly twice their proportion in the juvenile population (OJJDP *Statistical Briefing Book*). The over-representation may be the result of differential treatment within the juvenile justice system or societal factors such as poverty, school failures, and mental health problems. Some statistics pointing to differential treatment within the juvenile justice system are

- Rates of violent victimization are higher among blacks than among whites.
- The rate of violent victimization among American Indians (119 victimizations per 100,000 American Indians age 12 or older) is 2.0 times greater than among blacks,

2.5 times greater than among whites, and 4.5 times greater than among Asians (Rennison 2001).

- In 1997, non-Hispanic black juveniles were incarcerated in residential placement facilities at a considerably higher rate (1,018 per 100,000 non-Hispanic black juveniles in the general population) than Hispanics (515 per 100,000) and non-Hispanic whites (204 per 100,000).
- Non-Hispanic African American male juveniles were incarcerated in residential placement facilities at a considerably higher rate (1,176 per 100,000 non-Hispanic black male juveniles in the general population) in 1997 than Hispanics (902 per 100,000) and non-Hispanic whites (327 per 100,000).
- Non-Hispanic black female juveniles were incarcerated in residential placement facilities at a considerably higher rate (234 per 100,000 non-Hispanic black female juveniles in the general population) in 1997 than Hispanics (100 per 100,000) and non-Hispanic whites (75 per 100,000).
- Non-Hispanic black male juveniles accounted for 55% of youth in residential placement for robbery in 1997 and 30% of youth in placement for status offenses. They also accounted for more than 60% of placements for drug trafficking and more than 50% of placements for drug offenses.
- A one-day snapshot (October 22, 2003) showed that, except for Asian Americans, the custody rate in residential placement facilities was over-represented by minorities. The custody rates for African Americans, Latino/Hispanic Americans, and Native Americans were 754, 348, and 496 per 100,000 juveniles respectively, compared to 190 per 100,000 for White juveniles.

These juvenile justice statistics, when viewed in the light of the high prevalence of psychiatric disorders in this population, suggest that these youth have not been adequately served.

Mental Health Services for Children in the Child Welfare System

As of September 30, 2003, there were an estimated 523,000 children in foster care. Of those, 46% were in non-relative foster family homes, and 19% were in group homes or institutions. African American children and Hispanic/Latino American children represented 35% and 17%, respectively, of children in foster care. White children represented 39%. About 50% of an estimated 281,000 children who exited foster care during FY 2003 had been in foster care longer than 12 months. The median age of children in foster care was 10.9 years. The percentage of African American children in foster care decreased between FY 1998 and FY 2003, while percentages for Hispanic/Latino American children in care increased slightly. According to *Child Welfare Outcomes 2002: Annual Report*, 9.9% of children who entered foster care in FY 2002 were reentering the system within 12 months of a previous discharge.

As the first national longitudinal study to learn about the experiences of children and families who come into contact with the child welfare system, the National Survey of Child and Adolescent Well-Being (NSCAW) gathered information associated with more than 6,200 children from public child welfare agencies in a sample of 92 localities across the United

States. The survey findings from children and families who came into contact with the child welfare system through an investigation by child protection services reported that about half (46%) of children who came to the attention of the child welfare system were identified because of neglect, either "failure to provide" or "failure to supervise." The most serious types of abuse reported were physical abuse (27%); sexual abuse (11%); emotional, moral/legal, or educational abuse, or abandonment (11%); and reasons other than abuse or neglect, such as for mental health services or domestic violence (5%).

Risk assessment by child welfare workers of the caregivers at the time that investigations of child abuse or neglect were being conducted revealed that 8% of caregivers were abusing alcohol, 9% were abusing drugs, and 12% had recently been arrested. About 15% had a serious mental health problem, 7% had a cognitive impairment, and 5% had a physical impairment. Almost 8% of in-home caregivers reported they were currently receiving counseling or therapy for a mental health problem, and 12% said they needed counseling but were not receiving any. Two percent were currently receiving drug or alcohol treatment.

In terms of mental health of the children, 37% to 44% of all children in the study scored in the borderline or clinical ranges of the CBCL, but only 11% are receiving outpatient mental health services for emotional, behavioral, learning, attention, or substance abuse problems. A total of 7% are receiving specialty mental health services, with children most often receiving private professional help from mental health clinicians (5%), followed by mental health or community health center services (2%). Use of day treatment and therapeutic nurseries are reported less frequently (0.8% and 0.3%, respectively). Non-specialty mental health services are also being used, with 8% of the children reportedly receiving services from a school guidance counselor, followed by in-home counseling (3%) and services from a family doctor (1%). The study did not find significant differences in current use of mental health services in terms of the child's race/ethnicity.

The findings from the study indicate a need for education, parental-skills training, and mental health services for the caregivers. The study also shows a need for mental health services for children in the child welfare system.

Key Issues in Multicultural Children Mental Health Services

The cultural issues in adult mental health services also apply to children. The cultural issues are well documented and will not be repeated here. Instead, we highlight some of the key issues that are faced by all children, but that are more pertinent to children from minority backgrounds. These issues are under-identification of needs, under-utilization of services, shortage of providers, accessibility, and costs.

Under-identification of Needs

The recognition of mental health needs in children and adolescents is complicated by the developmental processes. Defining emotional and behavioral problems in children is not a

straightforward process. For example, assessment of “acting out” may be normal at a certain age, but the same “acting out” may be a sign of significant emotional concerns at another age. Moreover, culture can influence a caregiver’s perception of emotional and behavioral problems. For instance, Latino youths have the highest rate of suicidal ideation, yet they are less likely to be identified by their caregivers as having emotional problems. Any approach to determine the prevalence of children with mental health treatment needs must take into account developmental process and cultural norms. These issues have hindered progress in estimating the population prevalence of mental disorders in children and adolescents.

Epidemiologic data on the prevalence of children with serious mental illness in the United States is limited. No national prevalence study of mental illness in children and adolescents has been conducted. The large-scale, population-based Epidemiological Catchment Area (ECA) Study focused on adults ages 18 years or older. The National Comorbidity Study provided prevalence data for ages 15 to 54, which is only a limited coverage of children. The NCS-R, NLAAS, NSAL, and CAPES focus primarily on adults ages 18 and older. Although Kessler included interviews related to the NCS-R in a sample of approximately 10,000 adolescents ages 13 to17, those data are not yet available and presumably omit all the children ages 12 and under, where childhood disorders are present and many adult disorders begin to emerge. A comparable epidemiologic study of children’s mental health is desperately needed. Without such a study, defining unmet needs is a guessing game.

There were earlier attempts to undertake a national prevalence study of children’s mental health. One was considered as part of the ECA, but dropped. In 1989, the National Institute of Mental Health issued a request for applications for a multisite study to develop feasible, reliable, and valid methods for the assessment of mental disorders, risk factors, and service utilization in youths aged 9 through 17 years. A cooperative agreement was entered by NIMH with Columbia University, Emory University, Yale University, and the University of Puerto Rico to conduct a study later known as the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study. That made progress, but had limited sample size.

The MECA Study was conducted in Connecticut, Georgia, New York, and Puerto Rico. Trained interviewers conducted face-to-face interviews using structured diagnostic instruments with 1,285 pairs of youths and their adult caretakers in their homes. Disorders assessed using DSM-III-R criteria were phobias, anxiety, depression, ADHD, oppositional defiant disorder, conduct disorder, and substance use. The study estimated that the prevalence for any disorder, without accounting for functional impairment, was 32.8%. Functional impairment – mild, moderate, and severe – was determined from CGAS scores of less than or equal to 70, 60, and 50, respectively. The prevalence of any disorder with mild, moderate, and severe functional impairment was 20.9%, 11.5%, and 5.4%, respectively (Shaffer et al, 1996). There was fairly good agreement between the caregiver’s report and the youth’s report, although prevalence estimates based on the youth’s reports were slightly higher than those based on the caregiver’s reports.

Based on the work from the MECA Study, NIMH issued a request for applications MH-94-009: Cooperative Agreement for a Multi-Site Study of Mental Health Service Use, Need,

Outcomes, and Costs in Child and Adolescent Populations (UNOCAP) in 1994. However, that study developed internal difficulties and after two years was terminated without adding prevalence data from the intended design. There was an offshoot from that original agreement that provided results from a more focused regional study.

The NIMH-funded Great Smokey Mountain Study of Youth was conducted in the southern Appalachian mountain region of the United States. Children ages 9, 11, and 13 years were identified using public school registration records, and 4,500 children were screened for psychiatric symptoms with 1,015 recruited to participate in four waves of intensive annual interviews. A parallel study followed 323 Native American children at wave one. The three-month prevalence of any DSM-III-R axis I disorder in the main sample was 20.3%. The most common diagnoses were anxiety disorders (5.7%), enuresis (5.1%), tic disorders (4.2%), conduct disorder (3.3%), oppositional defiant disorder (2.7%), and hyperactivity (1.9%). African American children were found to have a significantly higher prevalence of functional enuresis than white children. No other racial difference in prevalence was reported.

A clinic-based study conducted at the Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh reported significantly higher rates of conduct disorders in African American adolescents compared to white adolescents (Fabrega et al, 1993). They found African American adolescents tended to receive Axis II diagnoses, whereas white adolescents were more likely to be given Axis I diagnoses.

Comparisons of the prevalence of psychiatric disorders among white, African American, and Mexican American youth were made in a recent study with 4,175 children ages 11 to 17 years who were enrolled in a large HMO in Texas. African American and Mexican American children had a higher prevalence of anxiety disorder than white children, but white children had a higher prevalence of mood disorders than African American children (Roberts et al, 2006).

A school-based study of Mexican adolescents and Mexican-American adolescents found higher proportions of psychological distress and higher rates of suicidal ideation among these youth on the U.S. side of the U.S.-Mexico border (Pumariega et al, 1992). A related study found much higher levels of drug use among distressed adolescents on the U.S. side than on the Mexico side, suggesting different coping strategies between the two groups (Swanson et al, 1992). A study of 1,886 children and adolescents ranging from 4 to 17 years old in Puerto Rico found the most prevalent DSM-IV disorders were ADHD (8.0%) and oppositional defiant disorders (5.5%) (Canino et al 2004).

Analyzing data from the 2001-2003 National Health Interview Survey, Pastor et al (2004) found approximately 5% of children ages 4 to 17 (2.8 million) had parental reports of severe/definite emotional or behavioral difficulties during the past six months. Racial/ethnic differences were found in parental reporting of their children having severe emotional or behavioral difficulty. Fewer Hispanic/Latino children had severe difficulty compared to African American children and white children. The prevalence of parental reports of severe emotional or behavioral difficulty for African American children and white children did not differ, but African American children had a higher prevalence of minor difficulty compared

to white children. Among children with severe emotional or behavioral difficulties, African American children and Hispanic/Latino children had a lower prevalence of contact with a mental health professional compared to white children, but no significant racial/ethnic differences in use of special education services were found.

Prevalence data on psychiatric disorders in Asian American children and adolescents is lacking. The Psychiatric Disorder among the Vietnamese-Origin Population in Texas: A Diagnostic Survey of 100 Households in Harris and Galveston Counties is the only community mental health survey of Vietnamese Americans in the United States. An early version of the Diagnostic Interview Schedule for Children (DISC) was used to assess mental disorders in these children. The most common disorder was separation anxiety (14.6%), with Vietnamese girls reporting the problem twice as often as Vietnamese boys (21.9% vs. 10.5%). Separation anxiety is notable because of the close-knit relationships in the Vietnamese family and also because a number of the children interviewed actually live apart from their parents (31.5%), having left a parent behind in Vietnam. Simple and social phobias were reported by 13.5% and 10.1% respectively, with more girls reporting simple phobias and slightly more boys reporting social phobias. The next most frequent disorders were conduct and oppositional disorders. The overall prevalence of any disorder was 36.0%, with girls having a higher prevalence (40.6%) than boys (33.3%). The full report is available on the Web at http://psy.utmb.edu/psyepi/vstudy/vstudy.htm.

A comparison study of psychiatric disorders in a sample of 27,537 children served in the CMHS-funded systems of care found significantly higher rates of diagnoses of anxiety and adjustment disorders and lower rates of depression and ADHD in Asian American compared to non-Asian children (Nguyen et al, 2004). It is not known whether the differences in diagnoses are due to differences in referral patterns or result from racial/ethnic bias in diagnostic assessment.

In summary, there is a large gap in knowledge of the needs for mental health services in children and adolescents, both for the general population and for minority ethnic groups. Methodological differences in existing studies make comparisons across racial and ethnic groups difficult. More importantly, there may be cultural influences in diagnosis that are not well understood. The *DSM-IV* is not consistent in its criteria for the impact of culture on diagnosis. Epidemiological studies are needed to investigate diagnostic issues and to estimate the need for mental health services for children across racial and ethnic groups. Mental health screening in schools can also be informed from population-based epidemiological studies. This is a necessary step toward eliminating disparities.

Underutilization of Mental Health Services

Minorities are less likely to utilize mental health services, partly because services are not available, are unaffordable, or their potential benefits are not recognized. The MECA study defined unmet mental health need as having a DSM diagnosis, with impairment, and no service use in the previous six months. The authors reported that 17.1% of children in the sample had unmet needs, with African American children having higher odds of unmet

mental health needs than white children (Flisher et al, 1997). In a separate study, Latino children were found to have higher rates of unmet needs than white children (Kataoka et al, 2002).

Analysis of unmet needs in the Patterns of Youth Mental Health Care in Public Service Systems (Patterns of Care) study revealed a significant difference for unmet needs by race/ethnicity (Yeh et al, 2003). The percent of unmet needs for African American, Asian American, and Latino children were 47.7%, 71.8%, 47.2%, respectively. All had significantly higher levels of unmet needs compared to white youths (30.7%).

Reasons for underutilization of mental health services by minority children and families are not fully understood. Data suggest that lack of knowledge of the mental health system and its operations may be a major problem. The MECA study reported that a significant 1.5- to 2-fold increase in unmet needs was due to concern about a child being hospitalized or taken away against the parents' will, youth refusing to go for treatment, or being unsure about where to go for help. Two top reasons for underutilization of mental health services reported in the MECA study were that utilization takes too much time or is inconvenient. Another reason that needs consideration is the high level of stigma associated to mental illness that exists in communities of color.

Shortage of Providers

The availability of services to treat children with serious emotional disturbance is paramount. The review of this issue is made problematic by the variety of different types of service providers and settings in which they practice. The mental health service system issues are discussed by Regier as the "De facto MH services system" (Regier et al, 1978, 1993). Different sectors including the mental health specialty, general medical, human services, self-help groups, family and friends, and voluntary support apply as much to children as adults, although the role of the school is more salient for children. There is a general shortage of specialty mental health providers including child psychiatrists (Thomas & Holzer, 1999; Thomas & Holzer, 2006), child psychologists and other providers serving children and their families. Pediatricians often provide mental health services to children because there are no child psychiatrists available, however there are challenges to pediatricians providing services, including a lack of training in mental health services, reimbursement concerns from insurers, their already busy schedule and related factors. Children with MH problems from minority ethnic groups appear to be routed more to school services or general social services than specialty MH sectors, unless these children's needs are overlooked and become more severe, in which case they may be referred to the juvenile justice system. The high rates of referral of minority children to the juvenile justice system are well documented (McCabe. et al., 1998).

Accessibility Issues

Services may be available, but there may be barriers to care for multicultural children and their families. One of the barriers to care arises from how a clinic or agency interacts with certain groups of clients. For example, Paul Adams and Nancy McDonald (1967) published a paper titled *Clinical Cooling Out of Poor People* to caution child psychiatric clinics about the use of tactics, whether intentionally or not, that discourage and prevent poor people from accessing specialty mental health care. Such tactics make the poor feel inferior and guilty for not being able to use the clinic's services, rather than expose the clinic's failure to serve the poor. Other barriers to access include time, transportation, lack of health insurance, and financial resources.

Interestingly, an analysis of data from the Patterns of Youth Mental Health Care in Public Service Systems (POC) study conducted in San Diego County with 554 non-Hispanic white youths, 332 Latino American youths, 282 African American youths, and 88 Asian American youths ages 6 to 17 and their parents found that minority parents reported significantly fewer barriers to care for their children than non-Hispanic white parents (Yeh et al, 2003). All of the children who participated in the study were receiving or had received services in one or more of five public sectors of care. San Diego County was funded by CMHS in 1997 to develop systems of care for children with serious emotional disturbance and their families. It is not clear whether the findings from the POC study may have been influenced by the efforts of the systems of care to build community-based, family-driven, and culturally competent systems of services.

Financing Services

Cost is a barrier to care. Nearly one-quarter of African Americans are uninsured. Medicaid covers nearly 21% of African Americans, and Medicaid payments are among the main sources of financing for mental health services.

The federal government has responsibility for providing health care to the members of more than 50 federally recognized tribes through the Indian Health Services (IHS). However, only one in five Native Americans reports access to IHS services. Native Americans living outside of reservations have limited access to HIS-funded care. Medicaid is the primary coverage for 25% of Native Americans. Recent policy changes enable tribes to apply directly for substance abuse block-grant funds, independent of the states in which they reside, but no such provision is available for mental health block grants.

About 21% of Asian Americans lack health insurance, and the rates vary within ethnic groups. For example, 20% of Chinese Americans and Filipino Americans lack health insurance compared to 24% of Korean Americans. The rates of Medicaid coverage for most Asian American subgroups are well below that of whites.

Insurance coverage for Latino/Hispanic Americans depends on their ethnicity, immigration status, and citizenship status. Latino/Hispanic Americans are over-represented among the

uninsured. Latino/Hispanic Americans are 12% of the U.S. population, but 25% of uninsured Americans are Latino/Hispanic Americans. Nationally, 37% of Latino/Hispanic Americans are uninsured at twice the percent for whites. Latino/Hispanic children are least likely to be insured, regardless of citizenship.

Appendix A

Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda
http://www.surgeongeneral.gov/topics/cmh/

Two related conferences formed the basis of a national action agenda on children's mental health. First, the Surgeon General's Conference on Children's Mental Health: Developing a National Action Agenda was held on September 18-19, 2000, with 300 participants representing a broad cross-section of mental health stakeholders including youth and family members, professional organizations and associations, advocacy groups, faith-based practitioners, clinicians, educators, healthcare providers, and members of the scientific community and the healthcare industry. Second, the National Institute of Mental Health and the Food and Drug Administration held a meeting called Psychopharmacology for Young Children: Clinical Needs and Research Opportunities on October 2-3, 2000, to discuss the issues cited in the meeting's title. The consensus recommendations and action steps from the participants at the national conferences formed the basis of this report.

Panel 1: Identifying, Recognizing, and Referring Children with Mental Health Needs. Several presenters and discussants raised the issues of culture in mental health care. They noted that African American and Hispanic American children are identified and referred at the same rates as other children, but are much less likely to actually receive specialty mental health services or psychotropic medications. The lack of follow-through is very often linked to trust in the doctor, the history of that relationship, as well as demographics and insurance status. However, other discussants pointed to the greater number of minority children who are incarcerated. They argued that when primary health care, school, child welfare, and the mental health systems fail to identify and provide appropriate services, children fall through the cracks and consequently end up in the juvenile justice system. Some research even suggested that there is a two-tiered child mental health service delivery system where poor children and children of color are tracked into the juvenile justice system while their white, middle-class counterparts are diverted to health and mental health systems.

Panel 2: Health Service Disparities: Access, Quality, and Diversity. The panel discussion argued that race has a strong effect on mental health measures, independent of SES. The recognition and identification of the need for mental health services are influence by racial, ethnic, and cultural differences in the expression of signs and symptoms of serious emotional disturbances and the caregiver's expectations of the child's normative behavior. For the same or lower level of aggressive behaviors, African American youth are more frequently referred to corrections, rather than to psychiatric hospitals, than their white counterparts. Minority children are less likely to obtain medication treatment for ADHD than white children. Many problems go unrecognized. Latino youths have the highest rate of suicide, but are less likely to be identified by their caregivers as having problems. Minority children tend to receive mental health services through the juvenile justice and welfare systems more often than through schools or special settings. Preliminary data from three national surveys of access to

specialty mental healthcare also point to high levels of unmet need for specialty care and substantial ethnic disparities in access to such care.

One of the eight goals from the report is to eliminate racial/ethnic and socioeconomic disparities in access to mental healthcare services. The action steps for this goal are:

- increase accessible, cultural competent, scientifically proven services that are sensitive to youth and family strengths and needs
- increase efforts to recruit and train minority providers who represent the racial, ethnic, and cultural diversity of the country
- co-locate mental health services with other key systems (e.g. education, primary care, welfare, juvenile justice, substance abuse treatment) to improve access, especially in remote or rural communities
- strengthen the resource capacity of schools to serve as key links to a comprehensive, seamless system of school- and community-based identification, assessment, and treatment services to meet the needs of youth and families where they are
- encourage the development and integration of alternative, testable approaches to mental health care that engage families in prevention and intervention strategies (e.g., pastoral counseling)
- develop policies for uninsured children across diverse populations and geographic areas to address the problem of disparities in mental health services access
- develop and support mental health programs designed to divert youth with mental health problems from the juvenile justice system
- increase research on diagnosis, prevention, treatment, and service delivery issues to address disparities in access to mental healthcare services, especially among different racial, ethnic, gender, sexual-orientation, and socioeconomic groups.

These action steps move the responsibility of mental health care for children across multiple settings in the family, schools, faith-based organizations, primary care, the juvenile justice system, and child welfare. A key observation by Dr. David Satcher is that “there is no mental health equivalent to the federal government’s commitment to childhood immunization. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented services, and low priorities for resources.”

Appendix B

Achieving the Promise: Transforming Mental Health Care in America
President's New Freedom Commission on Mental Health 2003
http://www.mentalhealthcommission.gov/

In July 2003, the President's New Freedom Commission on Mental Health released its report *Achieving the Promise: Transforming Mental Health Care in America.* The report included recommendations for transforming the mental health system for adults and children with mental illnesses. Goal Four of the report calls for early mental health screening, assessment and referral to services to be common practices. Furthermore, Goal Three focused on additional barriers to care that prevent racial and ethnic communities from seeking services, including different cultural ideas about illness, differences in help-seeking behaviors, and racism. Furthermore, the report mentions that without adequate training of professional to deliver culturally competent care, the burden of mental disorders on racial and ethnic communities will only deepen.

Goal 3: Disparities in Mental Health Services Are Eliminated.

"In a transformed mental health system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location."

Recommendations:

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

"For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening."

Recommendations:

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

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