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Pediatric Mental Health: Mechanisms Behind the Ethnic/Racial Disparities

In common with all medicine, the history of psychiatry is filled with novel and sometimes dangerous fads in diagnosis and in treatment. We are currently amidst a surge in these diagnostic categories. Within the past 30 years, the prevalence of childhood mental disorders have grown increasingly more common. The focus has shifted from Attention Deficit Hyperactivity Disorder (ADHD) throughout the 90's, to Autism spectrum disorders, Depression, and now Childhood Bipolar Disorder. Today, one in 88 American children are diagnosed with an Autism spectrum disorder (Center for Disease Control and Prevention), and the rates of Childhood Bipolar Disorder have increased by 40% in just 15 years (Frances, 2012). This rise in prevalence has been accompanied by a remarkable increase in the prescription of antipsychotic and mood stabilizing drugs for teenagers, children, and even infants. Though these diagnoses have grown popular in the field of psychiatry and mental health, the public continues to question their legitimacy.

Critics of the increasing "medicalization" such as Peter Conrad argue that the fault lies with American Society, as we have grown to expect too much from ourselves and today's youth. That is, it seems we've come to view behaviors beyond two standard deviations from the mean as an illness or an issue to be addressed. This perspective suggests that we often find comfort in placing the blame elsewhere, on biochemical imbalances or genetic defects, rather than blaming ourselves, poor parenting, inadequate schools, or the unrealistic expectations of society. Still, psychiatry has never validated

ADHD, Depression, Autism, or Childhood Bipolar Disorder as a biological entity. There are no blood tests or brain scans that can verify any psychiatric disorders as a physical abnormality or disease. Despite the frightening implications of societal expectations, I believe the creation of these categories has, and will continue to prove useful.

Regardless of critics' views, many of the symptoms associated with these "disorders" cause distress to the sufferer and often impair daily functioning. By labeling groups of people who share a common set of symptoms that are producing significant impairment in major life activities, we can learn more about what may be causing the problem and whether certain treatments and interventions can help better than others. In fact, studies have shown that children and adolescents with untreated mental health problems can have major consequences. For example, longitudinal studies have found that depressed children are at greater risk for later suicidal behavior, poor academic functioning substance abuse, and unemployment (Fergusson & Woodward, 2002). This information suggests that regardless of the origin of these "disorders" (biochemical, environmental, or imposed based on societal expectations), individuals benefit from treatment.

Unfortunately, not all treatments are created equal, and effective treatment is not easily accessible. In fact, there is a significant unmet need for mental services; A study by Kataoka, Zhang, and Wells (2002), found that only 21% of the children who need a mental health evaluation receive services. This data suggests that about 7.5 million children have an unmet need for mental health services. Not surprisingly, minority youth, despite equal if not higher need for services, often receive lower quantity and quality of mental health services. The disparities in access to and quality of mental health services for disadvantaged groups are due to several different factors, which makes a solution

particularly difficult. This paper will discuss the current state of disparities in pediatric mental health care, highlighting the challenges currently in place for ethnic/racial minority families. I will discuss several factors that contribute to disparities as they exist in: prevalence of mental health problems, parent education, access to services, treatment types, and funding for care. The article concludes with necessary approaches and specific recommendations.

Prevalence of mental health problems

Many identifiable risk factors for mental illness disproportionately affect minority children. It is not possible to explore racial/ethnic disparities in children's mental health without considering the role of poverty. While socioeconomic status can have a broad influence that is hard to disentangle from other issues, one significant influence is the living environment associated with lower socioeconomic status and minorities. Kataoka et. al. have suggested that risk factors, including poverty, food insecurity, isolation, and exposure to violence, significantly increase the likelihood of psychiatric disorders in youth. Several studies have documented higher rates of serious emotional disturbance amongst youth in the child welfare system, with rates at 50% (Garland, Hough, & McCabe, 2001). Additional factors that increase the risk for mental illness for minority youth are neighborhood exposure to violence, neighborhood social disorganization, repeated experiences of discrimination, and chronic exposure to racism. Data from a study conducted by Flannery, Wester, and Singer (2004), have suggested a link between mental disorders and level of exposure to interpersonal racism and violence. They also found a significant positive correlation between level of exposure to discriminatory acts and ethnic minority status. This suggests that ethnic minorities are more likely to experience racism and violence, which puts them at a greater risk for mental disorders. As a result, early interventions in the lives of ethnic and racial

minority children, intended to maximize their effective coping in these disadvantaged environments, could prove to be advantageous in terms of future outcomes.

Parent education and perceptions of mental health

Despite the higher prevalence of mental illness and disabilities in children of a lower socioeconomic status, many of these issues go unnoticed, and, thus, untreated. That is, recognizing a developmental delay, emotional disturbance, or behavioral problem requires having a certain level of education on the typical course of child development. A number of studies have found lower identification of mental health problems among minority caregivers, including Latino and African American parents, even when the youths exhibit the same level of problems or symptoms as their White peers (Alegria, 2002). If a parent is unaware of where their child should be developmentally, then many symptoms of these mental disabilities are perceived as bad behavior. Quite often, these disabilities are brought to the parents' attention by teachers or school counselors who are educated on these topics. Even then, many do not seek mental health services because they do not know where to go or what is available to them. A number of studies, including the National Longitudinal Study of Adolescent Health, have found that White individuals are more likely to self-refer for mental health services, or to seek suggestions from friends or family, while individuals from minority groups report less knowledge about available services.

Additionally, caregivers of particular minority backgrounds often have beliefs and perceptions of mental illness that can lead to different help-seeking behaviors and non-engagement in their child's mental health problems. Studies have shown that parents from minority groups may have different beliefs about the causes of emotional and behavioral disorders. For example, research has suggested that

individuals from minority cultures are more likely to attribute emotional and behavioral concerns to religious or spiritual issues, while White parents are more likely to provide biological explanations (Zimmerman, 2005). As a result, minority parents may be more likely to turn to a religious leader for guidance rather than seeking medical or psychiatric services.

Moreover, some minority parents may blame themselves for their child's emotional or behavioral issues. That is, parents may believe, or fear that others will believe, that their child's mental health issues are due to their own ability to raise a child. Zimmerman (2005) found that this belief is more prevalent among minority caregivers, which may contribute to a reluctance to seek treatment. These beliefs about the causes of their child's mental health problems not only influence willingness to seek service, but also the outcomes of the services that are obtained. If the family and the provider do not agree about the cause of the problems, the treatment approach may differ from the family's beliefs, thus increasing the likelihood that the child or family will not comply with treatment or prematurely drop out (Yeh, 2004).

Barriers to access to formal mental health services

At the same, a wide range of structural and sociopolitical constraints related to accessing services disproportionately affect minorities. These constraints include poverty and an insufficient availability of therapeutic and behavioral health services in minority neighborhoods. Geographic factors contribute most significantly to disparities in access to mental health services, to the extent that those of a minority background are more likely than Whites to live in areas characterized by low-quality care. Poverty can also have an indirect influence on other elements of accessibility, as individuals living in poverty may have less time to attend treatment, more limited means of transportation, higher levels of

stress, and fewer resources to address the needs of other family members.

From an anecdotal standpoint regarding my experience at the Jewish Board of Family and Children's Services (JBFCS), our Child Development Center is widely known as one of the most culturally sensitive programs throughout the New York metropolitan area. In fact, just three years ago, we relocated the center from 52nd street to West 139th street in Harlem. However, despite this attempt to create easier access for an underprivileged and underserved population, it still remains that 7 of every 8 children in the program is of a non-Hispanic White background. This example illustrates that even when they are able to access care, minorities are significantly underrepresented and undertreated compared with their White peers.

While poverty plays a significant role in determining access to high-quality children's mental health, it is not the only important factor. A study by Baxter (1989) examined parental access to assistance from services based on their occupational status and income level. The data showed that parents of lower-occupational status were least likely to receive assistance in finding services. However, Baxter proposes a combination of explanations for the status-related differences in information received. First, she suggests that it is less likely that parents of lower-occupational status know about or are referred to services. Secondly, it appeared that the services and facilities are also less likely to give the parents of lower-occupational status useful information. Lastly, it appears that parents of lower-occupational status are simply less able to apply and utilize the information they are given. Thus, the problem of disparities in access could be due to a differing ability to gather and utilize information as well as service providers' differential distribution of information.

In addition to poverty, the pervasive influence of racism must be addressed in order to

understand racial/ethnic disparities. Racism has the potential to influence mental health services on multiple levels, including individual, institutional, and social levels. Evidence has supported that some mental health providers administer care to individuals from minority backgrounds that is perceived as lower quality (U.S. Public Health Service, 2000). For example, this study found that providers spend less time, have fewer discussions about treatment options, and offer fewer opportunities for collaboration and compromise with patients from minority families.One national study found that approximately one third of African Americans said that racism was a major problem in receiving mental health care, in comparison to 16% of White families (Alegria, 2002).

On the most basic level, the foundation of mental health care lies in the interpersonal interactions between providers and consumers. Its effectiveness is determined in large part by the interactions and relationships between parent and service provider, and child and service provider. Studies such as Baxter's have found that providers' beliefs and expectations can be influenced by characteristics of patients, including their sex, age, type of illness, and race/ethnicity. Due to these beliefs and expectations, providers may interpret the behavior of the children differently depending on their racial/ethnic background. For example, the study conducted by the U.S. Public Health Service in 2002 found that therapists working with middle-school aged children involved in the juvenile justice system tend to rate the behaviors of Black students as evidence of criminal orientations, while White adolescents were seen as having potential mental health concerns.

The way in which mental health providers interpret their clients' behaviors and needs, in turn, affects the quality of treatment. To reiterate the findings from the U.S. Public Health Service study, providers were more likely to rush treatment, discuss treatment options less, and collaborate less with

minority families. Several studies have found that the manner in which mental health care providers treat their patients can influence the ways that adolescents and their families feel, think, and behave in powerful ways. Service providers may, intentionally or unintentionally, influence consumers' perceptions of themselves through implicit or explicit judgments on their competence and the nature of their mental problem. Studies have shown that if consumers from minority backgrounds feel rejected, judged, or misunderstood, they are more likely to discontinue treatment, and less likely to seek treatment at a later time (Van Ryn, 2003).

Treatment types

Disparities exist not only in initial access to care and completion of services, but racial/ethnic minorities are also more likely to receive treatment that is inappropriate and inadequate. More specifically, minority patients are less likely than White to receive the best available treatments for ADHD, anxiety disorders, depression, and anxiety disorders. For adolescent populations, psychotherapy is considered to be the most effective, and evidence-based, treatment for all mental disorders. However, both African American and Hispanic adolescents are significantly less likely to be enrolled in counseling services than are White children (Wells, Hilemeir, & Bai, 2009). This disparity can be partially explained by additional data from Wells et. al., which suggests that both private health insurance and a lack of insurance are negatively associated with counseling access. Insurance coverage as a contributor to mental health disparities will be further discussed in the "funding for care" section of this paper.

Despite the data suggesting that minorities are less likely to receive psychotherapy for mental

illness, an additional obstacle in receiving effective treatment is the lack of culturally appropriate services for minority youth. That is, there are several characteristics of American mental health services and psychotherapy which limit their effectiveness for minorities. For example, there is a shortage of mental health providers from diverse racial/ethnic backgrounds. Often, the mental health services that are available do not reflect the culture or value systems of youth or families from ethnic/racial minority communities. One of the primary concerns is that traditional Western mental health models tend to emphasize individuals as the focus of treatment rather than focusing on communities and families. Hispanic Americans, in particular, hold more collective values that emphasize interdependence and cohesion in the community rather than individualism (Alegria, 2002). An additional obstacle in psychotherapy may be that assessment approaches used to determine appropriate placements may not be designed for diverse populations, leading to inaccurate diagnoses and inappropriate treatment plans. There is an assumption that psychiatric symptoms are expressed uniformly across all cultural groups. However, studies have highlighted racial differences in symptom expression. For example, African American children and adults emphasize somatic symptoms (heaviness of the body, inability to sleep, general discomfort), while White individuals tend to focus on the cognitive aspects (Fergusson et. al., 2002).

In term of psychoactive drug treatment, White children are two times more likely to receive medication than non-white children. However, White adolescents receiving psychopharmacologic treatments also receive psychotherapy or other special education services in 89% of cases (Han & Liu, 2005). Ethnic minorities are significantly less likely than White children to receive psychotherapy and psychoactive drugs, but more likely to receive drug treatment without supplemental psychotherapy.

Several studies have indicated that patients who receive both psychopharmacologic treatment and psychotherapy have better outcomes of treatment than do patients receiving only psychoactive drugs (as referenced in Hamilton College course Adult Psychopathology). This suggests that of ethnic minorities who end up receiving treatment, they receive lesser quality than their White peers.

Funding for care

As was mentioned earlier, lack of insurance coverage may contribute to disparities in access to mental health care. While Medicaid has equalized access to some extent, insurance barriers are still frequently encountered as a barrier. Data from 2012 suggests that Latino children have the lowest rate of public or private health insurance coverage of any ethnic group (84%), compared with 93% of non-Hispanic white children, 91% of Asian children, and 89% of black children (Child Trends Data Bank, 2012). Even when individuals do have insurance, differences in the policies may reduce the amount or quality of coverage available for mental health services for lower-income individuals. In fact, a recent study found that, on average, 43% of the privately insured still have to pay $1000 out of pocket each month for services (Busch & Barry, 2009).

In 1997, a program called the State Children's Health Insurance Program (SCHIP), was created to give insurance coverage to children of uninsured families. As a public funding program similar to Medicaid, SCHIP was successful in expanding access to medical and mental health care services. However, a significant portion of minority parents were unaware of the enrollment process, and failed to enroll, despite having access (Chung and Schuster, 2004). Additionally, since 2004, budget cuts have prompted many states to drop nearly half-a-million children from SCHIP. Federal policy changes have

made eligibility for SCHIP significantly more difficult for many families. With no access to private insurance, the majority of children dropped from the SCHIP program will be left with no insurance policy.

The above funding only applies to psychotherapy, psychoactive drug therapy, and other related therapy services. If a child has a disability serious enough to affect their learning (such as Autism or ADHD), the process of receiving funding for a special education school is lengthy, complicated and involves a great deal of money upfront, as well as knowledge of the system. The process, as described by Ellen Fischer at the Child Development Center for JBFCS, can take as long as 6 months, and begins when students suspected of having a disability are referred to a group called the Committee of Special Education (CSE). If the parent chooses and is able to proceed, the committee arranges for an evaluation of the child's abilities and needs, which is conducted by mental health professionals. Based on these evaluation results, the committee decides if the student is eligible to receive special education services and therapeutic services. If the child is eligible to receive special education services, the committee develops an individualized education program (IEP) to meet the needs of the student. Based on the evaluation and the IEP, the committee along with the parents determine the student's placement. If students do receive a placement, full funding for the special education school is guaranteed.

This process requires a great deal of collaboration and free-time to travel between psychiatric evaluation centers, CSE centers, and potential special education sites. In approximately 50% of cases, students do not receive special education placement and funding the first time they go through the CSE process. Parents can either chose to send their child to a mainstream public school, hire a lawyer to return to the CSE and present their child's case in a new way, or pay out of pocket for the special

education facility. Unfortunately, schools for special education cost anywhere from $60,000-$100,000 a year, depending on grade-level. Fortunately, about 75% of cases that are resubmitted do receive funding, but working with a lawyer requires money that most parents of a minority background can not pay upfront, despite the long-term benefits it may have.

Conclusion

To reduce racial/ethnic disparities in pediatric mental health services, it is important to offer services that are accessible and reflect the values of communities of color. Unfortunately, little research has been conducted to determine the impact of family-focused, culturally-specific children's mental health services. Despite the shortage of this research, some recommendations can be made to reduce disparities. To truly eliminate disparities in children's mental health requires widespread changes at individual, organizational, and societal levels. While societal changes are an important factor in reducing racial/ethnic disparities in children's mental health care, the nature of those changes is far more challenging for the scope of my recommendations. That is, these racial/ethnic disparities will persist as long as socioeconomic disparities exist within the U.S. This paper will focus on the individual and organizational changes in pediatric mental health care.

One aspect of the mental health care system that could prove useful is in expanding educational and outreach efforts. More specifically, it would be helpful to conduct public health awareness campaigns to help families identify symptoms and understand the potential causes of mental health issues. Additionally, it is important to provide culturally-appropriate and user-friendly information about the full range of available services and their potential outcomes.

The next step in reducing racial/ethnic disparities in mental health care is to increase accessibility. For example, we could ensure that mental health services are available within high poverty areas or consider opportunities for providing transportation to services in other locations. To address the obstacle of insurance, policies and procedures could be reviewed to ensure that uninsured children are able to access mental health services when needed. It could also be valuable to work with CSE representatives and other referral agents to ensure that they are knowledgeable about available services, including culturally specific services, and able to make referrals that would best meet the needs of youth.

Some evidence has shown that models that include families in service planning and goal setting may provide a more useful approach to diverse cultural communities and help to reduce disparities (Pumariega et al., 2005). However, more research is necessary to better understand the needs of racial/ethnic minorities in order to refine treatment. I suggest conducting research, perhaps in partnership with youth and families, to develop evidence-based practices that are effective for children from diverse backgrounds. Although the wide array of challenges for racial/ethnic minorities can be a daunting task to conquer, it is an issue that should not be overlooked. Children with untreated mental health can have major developmental consequences, and the disproportionate number of racial/ethnic minorities affected only perpetuates the existing disparities in socioeconomic status.

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