Wilder Research

Engaging Youth and Families in Mental Health Services
Lessons Learned for Creating a Culturally-responsive System of Care in Ramsey County

The Ramsey County Children's Mental Health Collaborative (RCCMHC) continues to be interested in identifying ways that they can better meet the mental health needs of all children who live in the county, particularly youth and families of color. This summary includes information gathered from a focused literature review and key informant interviews conducted with local mental health service providers who focus on providing culturally-appropriate services to youth and families of color. Throughout the report, we often refer broadly to "youth of color" or use broad racial categories (e.g., African American or Southeast Asian youth) when describing barriers to accessing services, but make reference to the experiences of specific cultural communities, when possible. This approach reflects how information and experiences were presented both in the published literature and in our interviews with providers.

The summary begins with an overview of common challenges agencies and service providers experience when providing mental health services to youth of color. It then highlights promising practices that have been used by agencies to address these challenges and provides RCCMHC with recommendations to further promote and support culturally-appropriate services and service-delivery approaches.

Children of color are less likely to receive the mental health services they need

Mental health disorders affect an estimated 25 to 29 percent of children, with 20 percent experiencing mild functional impairment and an additional 5 to 9 percent having more severe functional limitations (U.S. Department of Health and Human Services, 1999). Approximately one-quarter of children have an identified mental health need, but very few receive adequate services. Recent studies estimate that only eight percent of children had at least one mental health visit in the previous year (Banta, James, Haviland, & Andersen, 2013).

Even when accounting for the severity of the disorder, there is evidence that ethnic minority children and adolescents have higher levels of unmet mental health care needs (Simpson et al., 2009). National data show that Asian American/Pacific Islander youth have the highest level of unmet health needs, followed by Hispanic/Latino youth (Banta et al., 2013; Ho et al., 2007). Local data have consistently shown that Asian American and American Indian youth are under-represented in the Ramsey County children's mental health case management system.

Many children who are identified with mental health needs and referred to services do not attend the first appointment or drop out of treatment prematurely. The literature estimates that up to three-quarters of youth end services prematurely (Armbruster & Fallon, 1994; De Haan et al., 2012; Kazdin et al., 1993; Kazdin & Mazurick, 1994). National studies have found that these problems are even more profound among ethnic minority populations. Youth of color are four times more likely to leave services early, compared to youth who are white (De Haan et al., 2012; Walrath, Ybarra, and Holden, 2006). In urban mental health centers, which may serve more children of color, up to 45 percent do not attend their first appointment (McKay et al.,

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2001). Studies focused on engagement have found that African American youth have higher rates of attrition before the first mental health visit (Alegría et al., 2012; Gonzalez et al., 2011).

Poor identification of mental health problems, lack of comfort seeking services, and underlying social determinants may all contribute to low engagement and retention in services

A number of factors may predict early drop-out from children's mental health services. These include treatment-specific predictors (e.g., a misalignment between the type of treatment offered and the needs of the child) and client-specific predictors (e.g., children living in a low-income or single parent household) (De Hann, 2012). For children of color, both treatment- and client-specific characteristics impact engagement and retention in mental health services. Children of color may be less likely to seek health services and experience the following: barriers accessing services, mistrust of providers, stigma around mental health treatment, and a lack of culturally relevant services. While these challenges are well-documented, it is also important to note that there is wide variation within the cultural communities being referred to more generally in this report and the extent to which these issues are barriers to accessing treatment may vary considerably (Gonzalez et al., 2011).

Poor identification of mental health problems

Both nationally and locally, Asian American youth continue to be most under-represented in the children's mental health system and to have unmet mental health needs. Parents of Asian descent are also the least likely to identify their children as having emotional or behavioral concerns of any degree. One local provider interviewed who works in the Hmong community noted that many Hmong parents do not associate behaviors they see in their child with mental health concerns. They are also more likely to think of mental health in terms of more serious conditions such as schizophrenia, and so are less likely to consider symptoms of depression (e.g. sadness) and anxiety as a mental health issues.

Poor recognition of mental health problems occurs with other cultural communities, as well. One local provider noted that many of the African American children they see have had long-standing but undiagnosed mental health issues, leading to behavioral problems, truancy, and poor academic performance. This provider felt that schools tend to contact parents only when their child is in trouble but do not offer support or solutions, heightening disconnect between parents and schools. As a result, instead of receiving the services they need, these children are labeled as "trouble kids" and parents get categorized as disinterested and unresponsive by the school.

Mental health concerns can also be difficult to identify among populations who tend to exhibit internalizing behaviors (e.g., depression, isolation) or to describe their symptoms as physical health complaints (e.g., stomach aches, headaches). As with other refugee populations, Hmong children and families have often faced the realities of war, poverty, culture shock, race and discrimination, and other challenges that increase the risk of psychological distress. Symptoms are often expressed somatically, making it difficult to identify mental health needs. The expression of mental health problems as somatic symptoms is also common in African immigrant communities. When this occurs, mental health problems may go unrecognized and untreated for long periods of time.

Lack of familiarity with mental health services, discomfort accessing services

The service delivery model used by many mental health service providers is unfamiliar or uncomfortable for many youth and families of color. For segments of the African American community, family members and the church community are often the primary supports, while clinical services are often a last option (Breland-Noble, Bell & Nicolas, 2006; McMiller & Weisz, 1996). Providers have also observed this locally. In addition, in many cultures, particularly American Indian and new immigrant or refugee communities, parents may first seek advice from elders or guidance from traditional healers. Among Southeast Asian families, for example, the support of the clan or traditional healing methods is often sought before or alongside Western services. National studies have shown that underutilization of services may be due to a fear of discrimination as well as a cultural belief that it is not appropriate to share mental health issues with outsiders (Banta et al., 2013; LaVeist et al., 2000; Sue & Sue; 1990). A local practitioner working with Southeast Asian communities stated that many families she works with have been hurt by the mental health system in the past, and so many families do not seek help until the problem is severe.

Lack of diversity among mental health providers can also be a barrier for youth accessing services. A lack of bilingual and bicultural providers can limit access to services for a number of ethnic groups, including foreign-born Hispanic/Latino youth, who are even less likely to utilize services than those born in the United States (Bridges, de Arellano, Rheingold, Danielson & Silcott, 2010; McMiller & Weisz, 1996; Yeh et al., 2003). A local provider working with the Hispanic/Latino community noted that dialects can vary widely across different Spanish-speaking populations, and being a member of the cultural community does not guarantee that a therapist is culturally competent. The lack of diversity of the mental health workforce was also seen as a barrier for Southeast Asian and African American populations, including – but not limited to – new immigrant and refugee groups.

A lack of knowledge about available mental health services has been identified as a barrier for Hmong children receiving services, but also likely applies to any new immigrant or cultural community where information may not be readily available in their primary language (Thao, Leite, & Atella, 2010).

An informant working with the African immigrant community in Ramsey County noted the challenges in coordinating services among providers, such as physicians, therapists, social workers, and case managers, especially when translation is needed. Cultural understanding of mental health can also present challenges in providing mental health care and building trust with these communities.

> *Defining mental health or developmental disability is abstract to the families that I work with, and it's hard for me to make it concrete. Sometimes there is conflict between what they expect from us and what we think they need from us.*

The literature also points to specific barriers and challenges that African American youth and their families face when trying to access mental health services. For many African Americans, there is a mistrust of mental health services and a hesitance to engage in a system that has a history of discrimination (Breland-Noble et al., 2006). This mistrust often includes concerns about children being mislabeled, mistreated, or even removed from the home (Breland-Noble et al., 2006; McMiller & Weisz, 1996; Pastore et al., 1998; Wu et al., 2001). Stigma can also affect a families' likelihood of accessing mental health care, with one informant noting that

from his experience, fathers from African immigrant communities show greater difficulty accepting diagnoses in their children and the need for help. Another informant also noted that fears of the mental health system and government agencies, particularly among undocumented individuals within the Hispanic/Latino community, may limit families' likelihood of accessing help.

Socioeconomic factors

Children and families living in poverty may have greater difficulty accessing mental health services for a variety of reasons. They may have greater difficulty affording co-pays or deductibles for services or have less reliable transportation options. Caregivers may be less likely to be able to take time off of work to bring their children to appointments. When parents work multiple jobs or are largely unavailable during the business day, it is more difficult to include them in the intake process for case management, an initial step that can open the door to a diagnostic assessment and referrals to appropriate services. A local provider noted that many youth are dropped from case management services if the case manager is not able to reach the parent after three attempts, even if the child qualifies for services. It isn't clear whether these socioeconomic barriers are more pronounced in some cultural communities than others. Although one national study (Thurston and Phares, 2008) found that African American parents perceived more barriers to seeking mental health care for their children, including cost and availability of viable services, other studies have found no differences (Yey et al., 2003).

Other considerations

Intergenerational issues can present challenges to mental health access. In one local study, Hmong youth reported their parents' willingness to engage in Western services as a factor affecting the likelihood of accessing mental health support (Thao, Leite, & Atella, 2010). A provider working with the Hmong community noted that parents might be willing to access mental health services for their children but fear disapproval from extended family members. Another provider working with the Southeast Asian community remarked that the current mental health system is very individualistic and adult-focused, which does not resonate with more collectivist cultural communities and results in children being "fit into" these models. These intergenerational barriers may also be present in other cultural communities; studies have not specifically considered these issues in other cultural communities. Many programs also require a legal guardian to sign off on services, which can present challenges for families with extended kin networks structures, where a grandparent or aunt, for example, may be the person who brings the child to appointments.

From a provider perspective, there are a number of treatment models that are family-centered and include a focus on understanding and addressing barriers to treatment. In Strategic Structural Systems Engagement (SSSE), Multisystemic Therapy (MST), and Telephone Engagement Interviewing, clinicians take responsibility for initiating dialogue with caregivers and family members about perceived barriers to treatment and actively work to address those barriers before and during treatment. Other close family members are called to assess treatment concerns as well. This approach has been particularly effective in increasing retention for families experiencing high levels of adversity (McKay, Nudelman, & McCadam, 1996; Painter et al., 2009; Szapocznik et al., 1988). While these treatment models have demonstrated positive outcomes, they require considerable staff time and necessitate more funding than is available through typical reimbursement for mental health services.

Local providers have used a number of promising strategies to engage children of color and their families in mental health services

Many of the difficulties that local providers identified as barriers to engaging children of color in culturally-responsive mental health services are consistent with challenges identified nationally in peer-reviewed journal articles. While some providers identified specific models or programs that they used to provide effective culturally-specific services, it was more common for providers to talk about their philosophic approach to service delivery and the practices they use to build relationships and respond to the family's concerns.

Listen to the needs and concerns of the family

While both national and local studies provide a broad overview of some of the barriers that make it more difficult to provide culturally-responsive mental health services, it is important to understand the unique perspectives and specific concerns of each family served by an agency. Many of the practitioners we spoke with underlined the importance of building trusting relationships with families that start with understanding their needs and concerns, and working to "meet the family where they are."

> *We believe [that is it important] to create the space for families to be able to teach us and tell us what's important to them…any cultural traditions, beliefs, norms, values – those kinds of things.*
>
> *We usually ask [the family] what they would have done if this problem had happened in their home country… We want to know where they are coming from.*

Provide education and outreach in communities

A number of providers also spoke to the importance of providing education and outreach as ways to reduce stigma surrounding mental health. For example, some providers held community conversations or attended meetings with culturally-specific resident groups or associations to present information about healthy childhood development and mental health. One provider noted that in these group discussions, parents are comforted when they hear from others who are experiencing similar challenges and when they learn that some of their challenges are an expected part of healthy childhood development. Education and outreach can also help families access the services that their children need, by either providing detailed information about services available in the county, or by providers themselves making the connection directly with families when they lead education classes and attend outreach events.

A provider that partnered with their local Early Childhood Family Education (ECFE) group to provide a series of educational sessions on healthy development and parenting skills felt that these meetings reached parents who would not have sought mental health treatment for their child's behavior on their own. As part of the program, they provided parents with a kit containing bubbles to teach children how to breathe when they are upset, teddy bears to promote nurturing, a microphone to give Hmong children a voice in their family systems, a ball to represent reciprocal relationship building, and two Hmong folklore story books. These kits were a reminder of the tools and skills they learned about in each session.

Maintain a highly-trained and diverse workforce

National studies have demonstrated that a culturally diverse staff can help reduce disparities in the engagement and retention of children of color in mental health services (Cross, Bazron, Dennis, & Isaacs, 1989). Having a clinician who is able to personally understand and bring up the realities of race, class, and gender can be particularly helpful. In addition, for youth and/or parents who speak languages other than English, it is strongly preferred that the clinician can speak the family's primary language (Copeland, 2006; Poderefsky et al., 2001). One provider shared their perspective on the importance of having staff who speak the same language as the client they serve:

> *We don't use interpreters… …I think that not having that 3rd person in the room, you're not making the connection with the person that's treating you, you're making a connection with an interpreter.*

All providers stressed the importance of having a diverse, culturally-competent, and highly skilled workforce. Multiple agencies spoke to the importance of having staff available who share the same culture and language as the families they serve. However, agencies face challenge because of a general shortage of highly-trained, culturally-diverse mental health professionals interested in working with children who have experienced trauma and who have high levels of need. One provider noted that staff can also build their capacity to provide culturally-responsive services by taking advantage of trainings and finding other ways to immerse themselves in a culture. The provider noted that being culturally-responsive is more than recognizing key cultural traditions or being aware of important cultural events; it is understanding the reason for their significance. Another provider also highlighted the importance of respect when working with Latino families, such as openly asking a client what a word means to ensure mutual understanding and to build trust.

Many of the providers we spoke with emphasized the importance of having a highly-trained work force. A number of agencies were using client-centered and trauma-informed service approaches and had staff who were trained in specific treatment models, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR). One provider underlined the importance of staying current on new evidence and research so that they can provide the most effective services. Their agency found that having both formal relationships with professors and interns who are learning about the most recent advances in the field helped them learn from and adopt newly-emerging best practices.

Provide holistic services and supports

Many families need a more holistic set of services and supports to effectively address their child's mental health problems and reduce barriers to accessing services (McKay, Nudelman, & McCadam, 1996). A review of published literature yielded a number of examples of programs used to not only provide mental health treatment, but to also reduce stigma, improve physical health symptoms, and respond to broader issues impacting the family as a whole. Examples of these culturally-specific intervention approaches include:

- Project SHIFA, a multi-tiered treatment designed to address adolescent trauma within the Somali refugee population. By working with family, community leaders, and school personnel on referrals, they were able to de-stigmatize the treatment and effectively engage youth (Ellis, Miller, Abdi, Barrett, Blood, & Betancourt, 2013).

- Collaborative care models, which involve a team of primary care physicians, case managers, and mental health professionals. The approach has been shown to be effective at engaging adults from multiple cultural communities, particularly Hispanic/Latino and African American adults (Interian, Lewis-Fernández, & Dixon, 2013). While this is specific to adults seeking care, it may also be applicable to caregivers seeking care for their children.
- Brief Strategic Family Therapy, where immediate and extended family members are included in the treatment of Cuban American youth in order to identify patterns of behavior within the family (Rosselló & Bernal, 1999; Szapocznik, Schwartz, Muir, & Hendricks, 2012).

Several providers talked about ways that they involve family members in treatment and focused on changes that were happening to both parties. In addition, one provider saw group therapy interventions as particularly helpful when working with clients of color.

> *We sometimes don't take into account the power that group therapy can have, especially in communities of color, and especially with communities that depend on each other for support and encouragement. I have seen tremendous amounts of progress not only in the sense of improved behavior with children but improved relationships between family members… Just having additional connections in the community [is important] because a lot of the families that we work with don't have their family members [living nearby].*

Some providers also offered examples of more holistic service-delivery approaches that they use in their work:
- The Department of Human Services (DHS) is allowing some school-linked grant recipients to meet with students and receive reimbursement for multiple sessions with the child before completing a diagnostic assessment, allowing providers to build a relationship with the child and family before focusing on the diagnosis and formal treatment plan.
- A provider working with disengaged youth facing mental health challenges described the services offered by their program as "case management lax services" because the more set structure of traditional case management services have not worked well for the population their agency serves. Under "case management lax services," the youth receive all of the services that fall under traditional case management without having to be enrolled in case management through the county.
- A provider in Hennepin County is providing "Plus Services" to offer care coordination, mental health treatment, and substance abuse treatment to youth during the school day. This helps to ensure the child is receiving all necessary services and is being offered as an alternative to expulsion. These collaborative efforts have also led to greater training and use of restorative practices to improve relationships between students and school staff and unintended inconsistencies in the application of suspension policies.

Use a strengths-based approach

The relationship between therapists and clients is arguably the most critical piece to building trust with families, particularly those from cultural communities that have been harmed in the past by the mental health and other institutions. Many of the practitioners argued for the importance of taking a strength-based approach with racial/ethnic minority families. A practitioner working with the Hispanic/Latino community noted that their organization's work is centered around putting the person before the illness. Another provider who designed a parenting program focused on mental health in early childhood in the Hmong community stated:

> *We… wanted to have a strength based approach, talking about how to promote families' emotional wellness. Talking only about the pathology and the problems isn't going to motivate people to give kids that extra padding to get through tough experiences.*

A strengths-based approach can be motivating for parents and children, and can support healing from poor past experiences with other service providers and historical trauma. A provider working with parents of youth who are disengaged from school emphasized forming a relationship between the school and students before a problem begins so that parents' first contact is not problem-based and in focusing on the parents hopes for their child:

> *We talk with parents about their hopes and aspirations for their child and not what they haven't done. Every parent who saw their newborn child and gazed in their eyes have all of these hopes, visions, and aspirations. Those things are still there today, but are somewhat dormant, because things haven't worked out as smoothly as they imagined. We are saying to them that we realize that they are a good parent.*

Many practitioners also pointed to the role that they play as a cultural liaison between communities and the mental health system. For example, although the use evidence-based practices should be encouraged, these services need to be talked about without jargon and in a way that youth and parents can understand. One way to make these connections for communities is to first present information in practical terms, such as in behaviors or physical symptoms they might notice in their children, and then introduce the clinical terms. This is especially important for cultural communities that might notice and respond to somatic symptoms first. In addition, because some communities might associate mental health problems with more severe mental illness, practitioners might also need to de-stigmatize the experience of mental health concerns for some families.

Consider ways to advocate for system-level change

While our conversations with providers focused on the ways that they are providing culturally-appropriate mental health services, a number of providers pointed out the need to address the broader social issues that disproportionately impact families and children of color, including poverty, disparities in education achievement and employment, and housing instability.

> *Whatever services we render, we run risks of just putting Band-Aids on huge issues if we don't look at the problems facing the whole community.*

At the program level, many practitioners suggested the importance of engaging with community leaders, churches, and schools in education and dialogue about mental health and stigma. Several practitioners emphasized the benefits of building long-term relationships with children and families they serve, who can then serve as advocates and ambassadors for the program. This involvement can promote greater mental health for the families through supporting connections and engagement, but can also lead to long-term systems change. A practitioner working in the Hmong community illustrated the role that empowering families to take on advocacy roles can play in interventions:

Our facilitator was really a strong advocate for saying, "if you don't ask, then Ramsey County will not provide. If you don't say that there is a need, those services will dry up and go away." You can have a Hmong provider in every aspect of services in the County and in our State if you are banging on the door. After 5 times of banging on the door they are going to get someone in there. That was really helpful to families. They felt encouraged by that, to not shy away from being hung up on because they spoke Hmong.

There is a great deal of support for culturally-specific programming in the literature and in the insights gathered from practitioners. At least one informant argued for a long-term vision, where culturally-competent practices are institutionalized within all mental health services. For this practitioner, having culturally-specific programs may prevent larger institutions from having to develop the skills and competencies to work effectively with all populations. The balance between reducing disparities in access while also providing culturally competent mental health care for children and families will continue to present both challenges and opportunities for the field in the future.

In our community, we tend to farm out the culturally appropriate piece, but if that could become part of the general institution. When we depend on external people, those services are good only as long as those services are around… I look at the unintentional message – if you belong to the "other," then go to the other agencies. There are other agencies doing cultural work.

The RCCMHC can play larger role in creating a children's mental health system that is culturally competent and effective of meeting the needs of all children and families

Based on the information gathered through the literature review and from interviews conducted with local providers, the following recommendations were developed as ways that the RCCMHC can help promote and sustain a more culturally competent children's mental health system of care:

Use Local Collaborative Time Study (LCTS) funding to pilot new outreach and service delivery approaches and prioritize evaluation funding to help identify promising practices that can be adapted by other providers. While the RCCMHC does use its LCTS funding to provide grants to agencies that have proposed ideas to provide more effective mental health services, there has not been a formal process in place to learn from the work done by these agencies and to consider ways to further expand and support this work. Focusing some evaluation resources towards these projects may be an important way to learn from these projects and encourage further adoption of promising approaches.

■ **Establish partnerships where mental health providers can provide psychoeducation and an introduction to mental health services in settings that are familiar and comfortable for caregivers.** There are a number of examples where providers are providing outreach and education to community residents in a variety of settings. Providers who have done this type of work have found that these sessions can help reduce stigma around mental health, provide parents with important information about healthy child development, and offer parents a more comfortable way to talk with mental health providers about the concerns they have about their child's behaviors. More formal support by the RCCMHC may help expand these efforts into more geographic areas within the county and to reach cultural communities who are currently underrepresented in the children's mental health case management system.

- **Provide trainings and offer educational resources to caregivers and key referral sources (e.g., teachers, faith leaders) that can help them better identify children with potential mental health problems and make referrals to appropriate resources.** Many families prefer to seek services and support from traditional healers and community leaders, rather than traditional mental health providers. Therefore, the RCCMHC may want to consider strategies to build relationships and connections to individuals who parents and families may confide in and who may see children exhibiting behaviors that suggest a potential mental health problem.

- **Promote a strengths-based and holistic service delivery approach that helps caregivers and youth identify their goals and measures of success.** Many agencies and individual providers currently use a strengths-based approach to provide mental health services, but find it difficult to have the time and flexibility to provide families with the services and supports they most need. The RCCMHC may be uniquely positioned to use LCTS dollars to support agencies that want to offer different types of support or flexible staffing options that are not reimbursable services, but that would better allow providers to respond flexibility to the needs of youth and their families. In addition, the RCCMHC should continue supporting the work of service providers, and supporting caregivers and families through the Family Service Committee and Family Support and Networking Meetings.

- **Consider opportunities to work across sectors to build a more diverse work force, including bilingual and bicultural mental health providers.** Short-and long-term strategies are needed to build a mental health work force that can respond to the needs of such a culturally diverse county. Short-term strategies may include providing training to interpreters so that they are better able to translate information about mental health symptoms and services in culturally-appropriate ways or developing cultural liaison or cultural broker positions that can help agencies provide better outreach and follow-up between appointments. The RCCMHC could also consider ways to foster partnerships between agencies to create shared employment positi ons for trained interpreters and/or cultural brokers. In addition, strategies are also needed to help professionals from diverse cultural communities attain licensure.

- **Amplify the concerns and challenges identified by caregivers when trying to access culturally appropriate children's mental health services and advocate for system-level change.** Many agencies who receive RCCMHC funding are providing services to youth and families who are underrepresented in policy decisions and who may be least likely to advocate for improvements to the mental health system. The stakeholders who participate in the RCCMHC are in a position to draw attention to challenges of meeting the needs of youth and families who live in Ramsey County, including factors that contribute to family instability, such as poverty. It may be helpful to clearly prioritize and develop strategies to respond to these system-level issues the RCCMHC's Strategic Plan, if they are not currently addressed.

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