ADDRESSING THE MENTAL HEALTH NEEDS OF RACIAL AND ETHNIC MINORITY YOUTH

— a guide for practitioners

APA WORKING GROUP FOR ADDRESSING RACIAL AND ETHNIC DISPARITIES IN YOUTH MENTAL HEATH

AMERICAN PSYCHOLOGICAL ASSOCIATION

Addressing the Mental Health Needs of Racial and Ethnic Minority Youth

A GUIDE FOR PRACTITIONERS

APA Working Group for Addressing Racial and Ethnic Disparities in Youth Mental Health

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WWW.APA.ORG/PI/FAMILIES/RESOURCES/MENTAL-HEALTH-NEEDS.PDF

Suggested bibliographic reference:
American Psychological Association, Working Group for Addressing Racial and Ethnic Disparities in Youth Mental Health. (2017). *Addressing the mental health needs of racial and ethnic minority youth: A guide for practitioners*. Retrieved from www.apa.org/pi/families/resources/mental-health-needs.pdf.

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The development of this guide was supported by funding from the William T. Grant Foundation and was inspired by their published report:

Alegria, M., Green, J. G., McLaughlin, K. A., & Loder, S. (2015). *Disparities in child and adolescent mental health and mental health services in the U.S.* Retrieved from http://www.mamh.org/Portals/0/Uploads/Documents/Public/Disparities%20in%20Child%20and%20Adolescent%20Mental%20Health.pdf

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//Introduction

Mental health is at the core of the health and well-being of children and families. Yet up to 50% of the U.S. population will develop a mental health disorder in their lifetime, with most disorders beginning in childhood and adolescence.

Racial and ethnic minorities are at particular risk for mental health disorders in adulthood, although interestingly, rates of those disorders are lower in adolescence, relative to the non-Latino white population. However, while some racial and ethnic minority youth experience lower rates of lifetime mental health disorders, their disorders tend to have a more chronic course. Reasons for differences in mental health etiology and outcomes among youth are briefly addressed in this guide.

Racial and ethnic minority youth, in addition to their racial and ethnic identity, have other identities pertaining to socioeconomic status, documentation status, sexual orientation, gender identity, and cognitive and physical ability status. These identities interact with each other and may produce unique challenges for youths. Some complexities they face include addressing multiple forms of discrimination and the disparities resulting from unequal access to and receipt of services as well as from laws and policies limiting their civil and human rights. An awareness of youths' intersecting identities should serve as the catalyst for action on the part of the practitioner, and such action should begin with an accurate assessment of the availability and accessibility of relevant and effective services for the individual.

The impetus for this practitioner's guide is the report *Disparities in Child and Adolescent Mental Health and Mental Health Services in the U.S.* (Alegria, Green, McLaughlin, & Loder, 2015), published by the William T. Grant Foundation. A task force, commissioned by the American Psychological Association's (APA) Committee on Children, Youth, and Families, set out to translate the findings from the report into a usable guide for practitioners. To this end, we summarize the factors described in the report that contribute to, or protect against, the onset and maintenance of mental health disorders for ethnic and racial minority youth. We also describe factors influencing their use of mental health services and provide concrete strategies for addressing the mental health needs of these youths.

// Mechanisms Underlying Disparities in Mental Health Outcomes Among Racial and Ethnic Minority Youth

According to the William T. Grant Foundation report (Alegria et al., 2015), the following are the primary factors that contribute to and perpetuate mental health disparities among ethnic and racial minority youth.

Socioeconomic Status

Disadvantages in socioeconomic status (SES) contribute significantly to mental health difficulties among ethnic and racial minority youth. About 39% of African American, 32% of Latino, and 36% of American Indian youth under the age of 18 live in poverty, more than double the rate of non-Latino Whites (14%) and Asians (14%).

Lower SES causes mental health disparities because children living in poverty are exposed to more stressors and have fewer buffers to counter that stress. Low SES interacts with poorer quality education and housing, unsafe neighborhoods, and more frequent experiences—or greater perceptions—of discrimination, racism, and oppression. These factors are believed to affect mental health directly by destabilizing social networks and the social structures supporting children, such as neighborhoods, schools, and housing. These unstable social structures may further impair youths' mental health indirectly by heightening their subjective experiences of stress and undermining their self-worth and self-efficacy. For example, parents of low-SES background may need to work multiple jobs to support their children financially. This may result in those parents having less time to spend engaged in activities with their children, such as reading to them, which can promote socioemotional learning. Children from low-SES backgrounds may thus be more likely to develop mental health problems as a consequence of these conditions and the lack of opportunities in their environment.

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Exposure to Childhood Adversities

Childhood adversity is an important determinant of mental health disparities in ethnic and racial minority youth. Adverse childhood experiences (ACEs) are stressful or traumatic events that include, but are not limited to, maltreatment, parental incarceration, neighborhood violence, family violence, and parental instability, all of which have immediate and lasting disruptive effects on youths' physiological development as well as their physical and mental health. Early and chronic exposure to ACEs is particularly detrimental and has been linked to difficulties in regulating emotion and behavior later in life, which is key to mental health and overall well-being.

Ethnic and racial minority youth living in low-income communities are exposed to a greater number of ACEs. Further, although adversities are experienced by all racial and ethnic groups, they can have more impact on racial and ethnic minority youth because such adversities interact with and influence other stressors that children face. For example, ACEs are associated with stressful family relationships and structures, including single parenting, and with early role patterns that perpetuate disparities in mental health, such as teen pregnancy, gang involvement, substance use, and school dropout. To address and, it is hoped, prevent such disparities, school personnel should be trained to identify, as early as possible, children who may be exposed to such adversities. To effectively reach and work with such children and families, the mental health system should maintain a close and viable working relationship with the educational system. Complimentary services provided by the two systems should be holistic and not segmental in nature and should treat the child and family member as intertwined parts of a whole rather than as discrete units.

Neighborhood-Level Stressors

The neighborhood context includes multiple components, such as levels of neighborhood safety, degree of neighborhood social support, extent of neighborhood racial and ethnic segregation, quality and quantity of neighborhood resources (e.g., recreational facilities, availability of healthy foods), and neighborhood norms. Variations in neighborhood context among racial and ethnic minority groups of children can increase inequities in access to formal and informal resources that affect mental health. These resources can include quality of education or the degree of social support. Neighborhood context can also undermine mental health by diminishing an individual's self-efficacy and overall sense of resiliency. For example, neighborhood violence, regardless of its source or cause, interferes with individuals' sense of control over their environment and has been associated with increased internalizing and externalizing symptoms as well as with posttraumatic stress disorder and academic difficulties.

A significant amount of racial trauma occurs in low-income communities of color; these experiences range from daily microaggressions to blatant acts of racism that "get under the skin" via stress, daily hassles, and stereotype threat. Implicit bias at the institutional level may increase youths' negative interactions with schools and police. Although these experiences have gained greater media attention, so too have societal messages denying these experiences and dehumanizing youths of color, particularly African Americans and Latinos. These racial tensions underscore the need for advocacy and community-based social and mental health services.

Family Structure

Sixty-seven percent of African American children and 42% of Latino children, particularly Puerto Rican children, live in single-parent households, compared with only 25% of non-Latino Whites. It is important that practitioners identify, understand, and carefully consider contributing causal factors to avoid inadvertently using these differences to support prevailing negative and overgeneralized stereotypes that stigmatize African American and Latino families. Such factors might include family separation due to immigration or deportation; social, judicial, and economic policies that make it impossible for partners to live together; and housing availability, policies, and restrictions. Regardless of the prevalence of such factors, family structure can contribute to mental health disparities in a number of ways. Deportation of a parent can lead to the placement of children in foster care or to a family's significant financial instability, increasing children's stress and compounding the grief of losing their parent(s).

Other ACEs such as maltreatment, family violence, and instability within the home are more likely to occur for children living in single-parent homes and in stepfamilies than for children living with both parents. Children raised in a single-headed household are more likely as adolescents to experience teen pregnancy and single parenthood, which may further contribute to mental health disparities. Particularly among racial and ethnic minority mothers, there is a strong association between being a single parent and risk for depression. It is important to note that maternal depression is related to poor child mental health outcomes.

Practitioners' Implicit Biases and Limited Cultural Competence

Practitioners' biases, prejudices, and stereotyping can also play a central role in contributing to disparities in quality of care and outcomes experienced by racial and ethnic minority youth. Many of these biases can be implicit—that is, they occur below conscious awareness. Negative implicit biases are automatic and may manifest as perceptions of minorities as less intelligent, more likely to abuse drugs and alcohol, more violent, and more at risk for treatment noncompliance. These biases about racial and ethnic

// Mechanisms Underlying Disparities in Mental Health Outcomes Among Racial and Ethnic Minority Youth (continued)

minorities impact diagnostic decisions. For example, a seminal study found that African American males were disproportionately and incorrectly diagnosed with more severe disorders (e.g., schizophrenia) than White males because of psychiatrists' biased beliefs that African American males were likely to be violent, suspicious, and dangerous. Disparate care extends beyond diagnostic practices to treatment experiences. Among racial and ethnic minorities, higher rates of mental disorders may be due in part to practitioners' limited use of guideline-concordant, evidence-based psychotherapeutic and pharmacological treatments as well as to their disproportionate use of involuntary commitment procedures.

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Although racial and ethnic minorities represent 30% of the population, approximately 90% of practitioners identify as non-Hispanic White. Furthermore, clinical training programs are largely characterized by ethnocentric monoculturalism. Consequently, theories about psychological health and psychopathology, and resultant treatment practices, primarily developed by White male scholars, may have limited generalizability to racial and ethnic minority patients. The lack of diversity in the mental health field means that ubiquitous implicit biases have few opportunities to be challenged and dismantled.

The consequences of unexamined implicit biases are tragic and profound, such as the inappropriate placement of minorities in the criminal and juvenile justice system. This excessive placement in the prison pipeline process is demonstrated by research indicating that untreated attentional and behavioral problems in racial and ethnic minority children are often viewed as signs of conduct disorder, thereby increasing the likelihood of academic disciplinary actions (e.g., suspensions, expulsions). Racial and ethnic minority students are disproportionately subjected to such actions, which are robustly associated with entry into the juvenile justice system. Given the rapid growth in racial and ethnic minority communities, disparities in the mental health system will worsen without systematic attention. Improved clinical training in cultural competence among practitioners will ensure that all patients receive effective, economical, and safe diagnostic and treatment practices.

// Protective Mechanisms Underlying Youths' Mental Health Outcomes

In spite of the aforementioned personal, family, neighborhood, and societal risks, many racial and ethnic minority youth develop into healthy individuals. Protective factors include the following:

Positive Home and School Environments

In the home, adults, including, but not limited to, parents, grandparents, and other extended family, foster resilience in children when they provide appropriate warmth, monitoring, support, and encouragement. The quality and character of school life (i.e., school climate) includes multiple domains, such as safety, supportive relationships, stimulating teaching and learning spaces, and the external environment, and are associated with outcomes that extend beyond the school environment, such as reduced aggression and violence. To develop and sustain positive school climates, many schools are adopting strengths-based programs, ethnic and racial socialization workshops, and anti-bullying programs; proactively sponsoring Gay–Straight Alliances on campuses; actively engaging in trauma-focused curricula (e.g., trauma sensitive schools–community partnerships); and providing staff professional development. Moreover, schools are increasingly investing in family engagement programs that form and strengthen trust and a shared commitment to the child's well-being. Also, school-based mental health screenings can be used for evaluation of, and intervention with, youth to promote healthy school involvement and timely referral for mental health services.

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Stable Parental Mental Health

Even in the presence of parental mental health challenges, stability in the home environment allows for the formation of emotional connections among family members through consistent and structured family routines. Children facing a parent's depression, for example, benefit from having access to other healthy adult role models who can consistently meet their needs, serve as trusted confidants, and build their sense of coping and efficacy. While positive parent–child interactions exist in single-parent households, the involvement of fathers during childhood has been shown to protect against adolescent psychological distress in non-intact families. Emerging interventions that aim to improve and support co-parenting when a parent experiences mental illness are critical to children's well-being.

High Levels of Social Support and Religious and Community Involvement

Supportive relations in the community, including peer interactions, have been associated with high youth efficacy, and in turn, with positive mental health and academic and vocational outcomes in high-risk environments. In addition, religious and community involvement of youths and their parents has been associated with stronger social networks and access to resources, as well as with civic engagement.

// Protective Mechanisms Underlying Youths' Mental Health Outcomes (continued)

Positive Racial and Ethnic Identity

A positive view of their racial and ethnic identity can be protective factors when children confront racism and discrimination. Positive racial and ethnic identity is associated with positive global self-esteem, which has direct implications for mental health. Racial and ethnic minority parents can support their children's positive identity by teaching them about race and ethnicity, a process also called racial and ethnic socialization. This type of socialization involves both the instillation of racial and ethnic pride and the preparation for confronting discrimination. When parents involve children in understanding and appreciating their heritage and offer a space for children to seek support, problem solve, and express their emotions about social injustices, they promote the child's development of positive self-esteem, efficacy, and coping.

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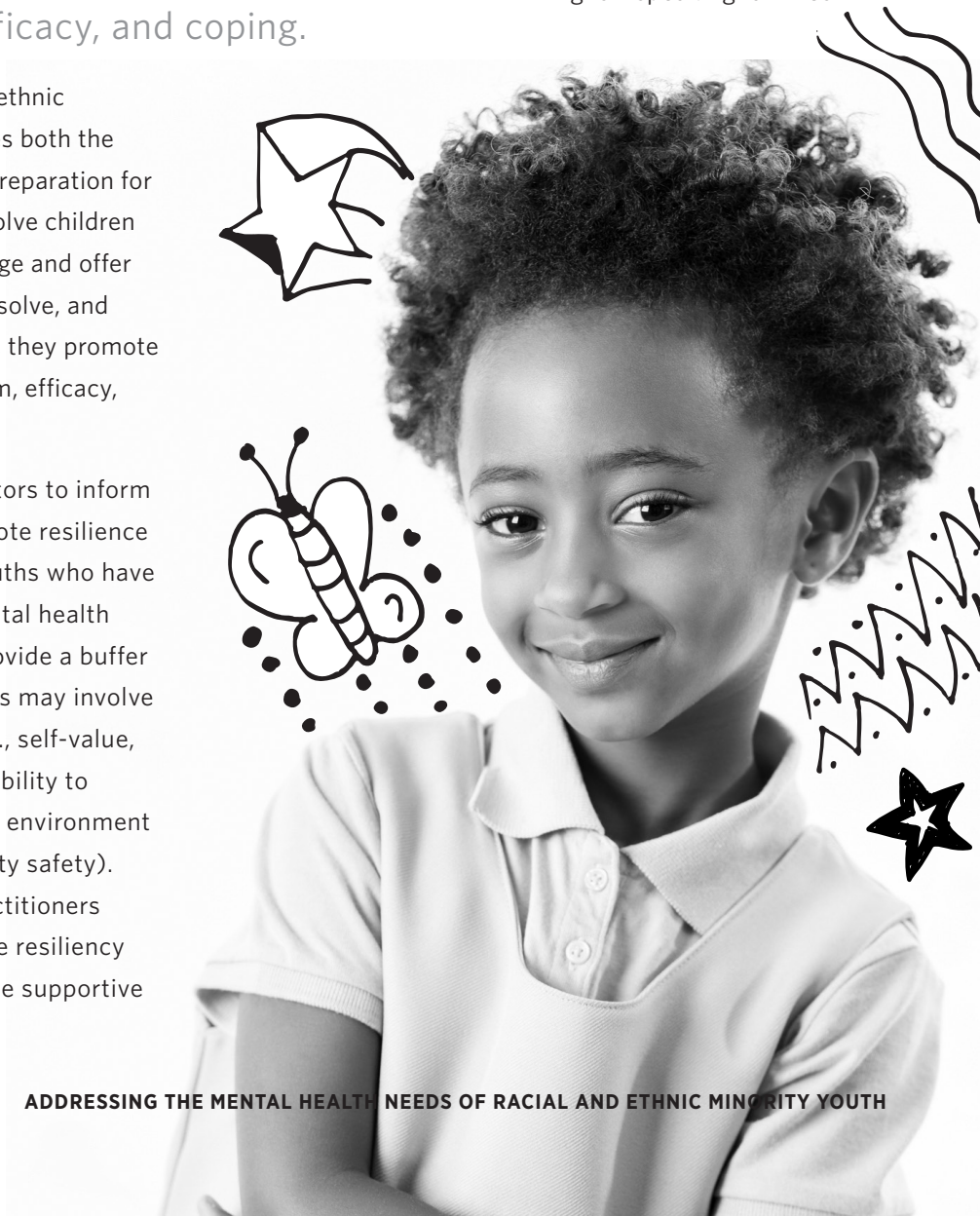
Practitioners should use these protective factors to inform their approach to treatment in order to promote resilience in racial and ethnic minority youths. Even youths who have experienced ACEs can achieve favorable mental health outcomes when protective factors help to provide a buffer against perceived stressors. Protective factors may involve characteristics of the youths themselves (e.g., self-value, resiliency, and self-efficacy across settings; ability to self-regulate emotions and behavior) or their environment (e.g., support of friends and family, community safety). In adopting a strengths-based approach, practitioners identify the presence or absence of protective resiliency factors and then use this information to locate supportive resources for the child. For example, if a child's parent is diagnosed with a medical illness that limits the parent's ability to support the child, a practitioner could then look to other positive adult role models in the child's extended family, school, community, or religious group to provide the necessary assistance and support. To this end, mental health and social services should maintain updated lists of persons and community groups that are capable of serving diverse, nontraditional, and non-English-speaking families.



// Determinants of Mental Health Care Use for Racial and Ethnic Minority Youth

Racial and ethnic minority youth demonstrate low rates of mental health service use in both community and school settings. Moreover, when they enter treatment, they often face barriers that make it difficult for them to remain in treatment and to improve.

Less than 40% of youths with mental health needs receive mental health services, and racial and ethnic minority youths are more likely to have unmet mental health needs compared with their non-Latino white counterparts. Disparities in service use are multiply determined and include individual, practical, attitudinal, and systemic factors coming together to influence the likelihood that youths with mental health needs receive services. For example, practical barriers like lack of insurance coverage, difficulties with transportation, or availability of services on weekends or evenings disproportionately impact minority families. Attitudes and beliefs about mental health services, including concerns about stigma, differences in identification of mental health needs, and differences in explanations for children's difficulties, are also more likely to result in fewer racial and ethnic minority youths using mental health services. Furthermore, systemic factors, such as a lack of linguistically appropriate services in the community or lack of availability of culturally competent or ethnically matched practitioners, may create additional access barriers for minority families.

Practical barriers like lack of insurance coverage, difficulties with transportation, or availability of services on weekends or evenings disproportionately impact minority families.

While minority youths have higher rates of unmet needs overall, research also suggests that individual factors, such as the types of problems youths have, also contribute to patterns of service use. For example, racial and ethnic minority youths with externalizing problems have a high probability of being connected with mental health services, whereas those with internalizing problems have higher rates of unmet needs relative to their non-Latino White counterparts. Beyond initial access to services, racial and ethnic minority youths are less likely to receive quality care and more likely to experience ongoing factors that impact engagement in and retention of services. Thus, disparities in service use can result from a range of factors affecting referral, access, and/or engagement.

When considering the service use of children and adolescents, it is also important to note that they rarely refer themselves for services. Thus, adult gatekeepers of mental health services (e.g., caregivers, teachers, and service providers) are largely responsible for identifying need and facilitating referrals and access to services. Barriers and facilitators to service use likely occur at this adult-gatekeeper level. In this manner, practitioners represent an important gatekeeper with the ability to identify mental health needs and support families in accessing and engaging with needed services.

// Role of Practitioners Within the Clinical Encounter

As described previously, there are many factors that impact—both directly and indirectly—the emergence of disparities in mental health need and service use among racial and ethnic minority youth. It is clear that achieving better mental health for these youths involves more than the youths themselves (e.g., their home environment, neighborhood, and cultural background). Although factors contributing to these disparities may occur long before a practitioner has contact with the family, practitioners can play an important role in addressing and eliminating these disparities once families come into contact with mental health services. By recognizing factors reviewed previously and understanding their potential impact on referral, identification of need, diagnosis, and engagement in and retention of services, practitioners can be better equipped to deliver services in a way that mitigates the negative effects of mental health disparities. Below are some recommended ways to acknowledge these factors within the clinical encounter to maximize the likelihood that practitioners understand the needs and contexts of families that present for services and to support those engaged with services.

Culturally Grounded Clinical Practice

Practitioners who practice **cultural humility** in the clinical encounter are better able to connect with and serve their racial and ethnic minority clients. Cultural humility involves reflecting on what one knows about a particular group and what one does not know about the unique values, experiences, meanings, and goals of the individual in the therapy room, regardless of their group membership (Falicov, 2014). Culturally humble practitioners also reflect on how personal life experiences may bias their familiarity with and acceptance of their clients' lived experiences, and they learn from their clients by adopting an "other-oriented" approach to therapy. Humility can allow practitioners to approach their work with a client with healthy curiosity, rather than with overly confident and potentially erroneous assumptions about the client (Sue & Sue, 2002). Striving to be culturally humble, rather than competent, facilitates lifelong learning.

> Practitioners who practice cultural humility in the clinical encounter are better able to connect with and serve their racial and ethnic minority clients.

Cultural humility is more than learning from clients. It involves intentional and honest self-reflection about what practitioners bring to the clinical encounter in terms of lived experiences and cultural influences. Some of these influences include age and generational status, developmental or other disability, religion and spiritual orientation, ethnic and racial identity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender. To initiate this process, practitioners can begin by writing down all of the cultural influences, past and present, that explain their own identity. Next, they should examine which ones were the most and least salient. They should then ask what makes these influences vary in salience. Is it lack of experience with an influence, such as being an able-bodied practitioner and not knowing any individuals with disabilities? Or is it bias, such as their holding egalitarian values but having grown up in a household prejudiced about race? Or is it both?

Practitioners should also examine how their diverse cultural backgrounds shape their worldview—that is, their own beliefs, decisions, and interactions. Practitioners may do this through self-reflection or in consultation with a trusted clinical supervisor. By recognizing which influences grant them privilege in society, they can become more aware of their blind spots as a result of that privilege and relative to their clients who differ from them. Even practitioners who share many influences with

their clients need to consider the personal experiences that have shaped both their worldview and that of their clients, acknowledging what they know and what they do not know. Every person is different, and regardless of who is in the room, every encounter is a cultural encounter.

Culturally responsive services can result in greater client engagement, healthier therapeutic relationships, and better treatment retention and outcomes for racial and ethnic minority youth. For instance, therapeutic interventions that are adapted to reflect the client's cultural metaphors, contexts, assumptions, and language have demonstrated their effectiveness with Puerto Rican teenagers (Roselló & Bernal, 1999). Meta-analytic approaches have not only confirmed the effectiveness of a cultural adaptation approach but also highlighted the reason for its efficacy related to nonadapted treatments (Smith, Domenech Rodriguez, & Bernal, 2011). Those treatments that address a client's own cultural views of his or her illness were found to produce the most positive outcomes (Benish, Quintana, & Wampold, 2011). Thus, practicing cultural humility can be beneficial for the practitioner, the client, and their shared therapeutic alliance.

The APA (2003) has encouraged increased implementation of multicultural guidelines in clinical practice and psychology graduate training. Generally, these guidelines recommend that practitioners recognize the importance of multicultural sensitivity and understanding within their work as well as the biases they may hold that impact their ability to do this. Also, practitioners are encouraged to use culturally appropriate skills within clinical practice and to promote culturally informed policy development at the organizational level. The Substance Abuse and Mental Health Services Administration (SAMHSA; 2014) also developed a Treatment Improvement Protocol (TIP) series as an easy reference guide for practitioners. TIP 59 is dedicated to improving cultural sensitivity among practitioners and helping them reflect upon their practice.

Practitioners can demonstrate a commitment to the practice of cultural competence by using the following attitudes and behaviors:

- **Respect** (exploring, acknowledging, and validating the client's worldview)
- **Acceptance** (maintaining a nonjudgmental attitude toward the client)
- **Sensitivity** (understanding the client's experiences of racism, stereotyping, and discrimination)
- **Commitment to equity** (proactively addressing racism or bias as it occurs in treatment)
- **Openness** (recognizing the value of traditional healing and help-seeking practices)
- **Humility** (recognizing that a client's trust is earned through consistent and competent behavior rather than through the potential status and power ascribed to the role of the practitioner)
- **Flexibility** (using a variety of verbal and nonverbal responses, approaches, or styles to suit the cultural context of the client)

Considering the Individual's Context and Intersecting Identities

Contexts

When working with racial and ethnic minority youths, practitioners should recognize the contexts in which the youths live, work, and play. To do this, practitioners should adopt a social ecological framework, which broadly considers the complex interplay between individual, family, community, social, cultural, and political factors and relationships between these variables in promoting positive outcomes. In terms of social and political factors, practitioners should acknowledge factors such as culture, SES, gender, level of community resources and social support, discrimination, and social policy. Social policies are guidelines, principles, legislation, and activities that affect

the living conditions and welfare of children and families. An example of social policy is the provision of child care subsidies for low-income families that are financed through state funds or federal grants. Such subsidies can impact child mental health by improving parents' ability to purchase more or better quality child care or by helping families advance their overall socioeconomic capacity by allowing parents to work, attend school, or obtain job training.

It should be noted that acknowledging, understanding, and accepting the prominent role that contextual factors play in determining the mental health status of individuals is but one of the first steps in identifying, developing, and taking culturally appropriate and effective actions that result in positive outcomes for them. With this in mind, practitioners should employ actions or treatments that carefully consider the context of the child. For example, using a trauma-informed approach when working with youths and their families who have experienced ACEs builds resilience by focusing on their strengths across multiple systems (e.g., family relationships, social connections, level of community support) (Conradi & Wilson, 2015). For the sake of cost effectiveness and expediency, the actions practitioners take should not be focused solely on the individual. Working with the family to understand the young person's circumstances is critical to addressing the youth's most pressing concerns and building an alliance with the family to support the youth's healing. Because many racial and ethnic minority families have been victims of racial trauma, practitioners should explore how these experiences have affected the health of the family. Practitioners should coach parents on how to communicate with their children about race and ethnicity in ways that foster ethnic/racial pride and prepare them for future encounters with racism (Coard, Wallace, Stevenson, & Brotman, 2004).

Because many racial and ethnic minority families have been victims of racist trauma, practitioners should explore how these experiences have affected the health of the family. Practitioners should coach parents how to communicate with their children about race and ethnicity in ways that foster ethnic/racial pride and prepare them for future encounters with racism.

If a similar problem, such as trauma, is presented by a significant number of youths, and if it appears that the problem is associated with similar causal contextual factors, practitioners should attempt to address the external causes and not insist on treating the internal symptoms one client at a time. For instance, if a large number of youths are dealing with anxiety and stress that appear to be associated with racism or they are living in an unsafe area, then practitioners and their organizations, in collaboration with other organizations and community agencies, should take actions to address issues of justice and safety. Doing this may take time and energy but will increase the well-being of a greater number of youths and families.

A growing number of therapeutic tools that approach presenting problems from a broad contextual perspective are available. Such tools include the following:

- **Ecomaps**—Visual depictions of the relationships between individuals or families and their environment, including support networks, which practitioners can use to conceptualize the client's relationships—both positive and negative—and note the flow or lack of resources the client has (see Appendix A). Ecomaps can be especially useful to map areas of disconnectedness or social isolation that may exist.

- **Culturagram**—A tool that illustrates various facets of culture, such as legal status, reasons for relocation, discrimination, and values about education and work, to aid practitioners in treatment planning and achieving greater cultural understanding (see Appendix B). For many clients, it may be useful to create culturagrams at multiple points during therapy as an assessment of coping with and agency in addressing community and social issues.

Intersecting Identities

Although all youths hold multiple identities, some identities may be more visible than others. For example, a young person's race and ethnicity may be visible, but his or her citizenship status or sexual orientation may not. Even the personal meanings about race and ethnicity may not be visible. Similarly, a person's gender may appear to be visible but may not reflect his or her true gender identity. Some religious affiliations may be visible based on the person's attire, but others may not. Yet all of these identities are important in the young person's lived experience and to his or her worldview. Moreover, some intersecting identities may heighten the young person's stress. For instance, a young Latino male who is struggling with his sexual orientation and who is part of a traditional family that lives in a barrio (ethnic enclave) with minimal access to personal, social, economic, and health resources may find himself facing overwhelming psychological and social problems and challenges. Practitioners could look to existing minority stress interventions, which have predominantly been developed for LGBTQ populations, to (a) normalize a youth's distress resulting from minority stress, (b) "unpack" the long-standing impact of minority stress on identity and well-being, (c) build on the young person's strengths in overcoming long-standing obstacles, and (d) empower the young person to affirm his or her identities and values in their daily lives (Pachankis, 2014). These interventions for minority stress have clear and immediate application to other minority groups.

Although all youths hold multiple identities, some identities may be more visible than others.

Engaging the Client

Because of some of the barriers mentioned earlier, racial and ethnic minority youths may be unable and/or particularly resistant to engaging in mental health treatment. However, there are steps practitioners can take to promote engagement in the treatment process.

- **Establish a receptive environment:** One of the first things that must be done is to establish an environment that is supportive and inclusive. Such an environment would include close and ongoing working relationships between youths and their families, teachers, counselors, and mental health services. A contact person located in the school or in a relevant community organization should be identified. This person should be highly visible and accessible and should work to establish and expedite contact between the targeted youth and the appropriate service providers. Suffice it to say that barriers to attaining needed help should be identified and quickly removed. Establishing such an environment may take time, effort, and resources; however, in the long run, the benefits will far outweigh the costs.
- **Encourage participation in school/community forums:** School/community forums on topics relevant to mental health should be provided in nonstigmatizing and familiar surroundings. Such forums should be sponsored and provided by persons who are trusted by and familiar with the community. The forums should be provided periodically to inform and remind parents and guardians of the importance of their children's well-being.
- **Practice motivational interviewing:** Motivational interviewing (MI) is a clinical approach in which practitioners uphold four principles to help clients make

behavioral changes: express empathy and avoid arguing, develop discrepancy, roll with resistance, and support the client's self-efficacy. Using this therapeutic technique can empower clients by resolving their ambivalence and may increase their willingness to receive treatment. Although MI can be useful with many types of clients, it is particularly so in cases of involuntary treatment or when alcohol or substance abuse are the primary concern.

- **Assess barriers to treatment:** To keep racial and ethnic minority youths engaged in therapy, practitioners must recognize the barriers and stressors youths encounter and note whether these change over time. Some barriers, like finding a bus route to the appointment, may be present only initially, while others, like parents' disapproval of treatment, may have a more enduring effect on youths' engagement in therapy.
- **Foster a strong, culturally sensitive therapeutic alliance:** Practitioners must be aware of their potential for committing microaggressions with their clients. These acts consist of seemingly nonharmful actions—whether intentional or unintentional—that convey hostile, derogatory, or negative racial slights and insults (i.e., racial microaggressions) (Sue et al., 2007). In therapy, these microaggressions may result in the client's self-doubt, frustration, and perceived isolation, in turn affecting his or her engagement in therapy. Moreover, even when the alliance is strong, practitioners should honor the client's resistance in therapy as a potentially healthy reaction to chronic feelings of powerlessness within contemporary society.
- **Explain the process:** Regardless of a person's cultural and ethnic background, if he or she has never accessed mental health services before, it is of the utmost importance to provide a brief overview of what to expect from the therapeutic process. Doing this will not only put the client at ease but also serve to expedite the development of the therapeutic alliance.

//Role of Practitioners Outside of the Clinical Encounter

Working Within the Organization

Concepts such as cultural humility and recognizing multiple systems of influence should extend beyond one-on-one relationships and should also apply to the organization within which practitioners work. Being inclusive and reflecting a sincere value and appreciation for diversity within an organization allows youths and families to feel safe and prioritized, which impacts their openness to the clinical encounter. A practitioner's organization regularly needs to assess its mission and the services it offers as well as its internal structures and processes to ensure they are appropriate, beneficial, and accommodating to racial and ethnic minority clients and staff (Briggs & McBeath, 2010). Doing so can help ensure the organization is sensitive to the changing demographics and needs of the community while minimizing disparities in access to mental health treatment among racial and ethnic minority youth. Some self-assessment points may include:

- Does my organization have culturally relevant and linguistically appropriate programs (e.g., outreach), activities (e.g., forums), and resources (e.g., community educators, "promotoras") to inform the community regarding mental health issues and services and, in particular, the services and support that the organization provides relative to these issues?
- Do my organization's hours of operation potentially prevent certain types of individuals (e.g., those with limited flexibility in work schedule) from receiving services?
- Is my organization's location accessible to as many individuals as possible? Are different transportation options made clear and available to clients?
- Does my organization make clear all of the ways in which potential clients can go about initiating treatment?
- Do the service providers within my organization speak more than one language? Are the languages they speak appropriate for the population(s) the organization serves?
- Are all information, questionnaires, and other materials, regardless of format, in the preferred language of the youth and family? Is the information provided at the appropriate reading level of the client?
- Are the services offered by my organization compatible with the language(s), norms, beliefs, and values of its clients?
- Does the training administered to organization personnel include cultural competency and information processing (i.e., inherent biases) modules?
- Does the organization provide training to ensure that all service personnel are aware of the existing regulations and policies pertaining to the provision of services to diverse populations? There are cases in which services are denied to racial and ethnic minority individuals in need of serious help because of a lack of knowledge or misunderstanding of the services that can and should be provided to such persons (e.g., the undocumented, the uninsured).
- Does the décor or appearance of my organization potentially prevent certain individuals from seeking services?
- Are services provided consistent with evidence-based practice?

There are also resources available to assist with improving cultural responsiveness within an organization. For instance, SAMHSA's TIP 59 (2014) presents best practices for improving cultural responsiveness at the individual level as well as at the programmatic and organizational level. Key topics covered include culturally responsive evaluation and treatment planning; the planning, evaluation, and monitoring of organizational cultural responsiveness; and tools for assessing cultural responsiveness in individual mental health service providers as well as in treatment programs and organizations.

Outreach and Collaboration in the Community

To minimize disparities in mental health access and treatment, practitioners' work should also extend to the communities in which their organizations are located and their clients live. Conducting preventative community outreach and fostering relationships with key community members are important to promote the well-being of clients as well as those in their social systems (e.g., family, friends, and neighbors).

First, practitioners can educate or train members of the public and provide them with the knowledge and skills they need to help their own communities deal more effectively with challenges. For example, through a focus group, members of a Latino community gave input to shape the content of a mental health literacy video intended for low-income families. As a result, the video used culturally appropriate language understandable to parents in that community and discussed parents' stated concerns. Doing this not only helped normalize the experiences of Latino parents who subsequently watched the video but also opened the eyes of the practitioners as to what Latino parents see as barriers to care (Umpierre et al., 2015).

Second, practitioners can establish relationships with key community members to provide a better mental health "network" for clients. Because of the various barriers that prevent racial and ethnic minority youths and their families from seeking or remaining in mental health treatment, these individuals may turn to other sources for assistance. For instance, churches are often a primary source of information about health and social and spiritual support for Latinos. However, religious beliefs are rarely addressed in culturally congruent care. Out of this incongruence is a potential partnership between practitioners and churches to discuss faith-based stigma around mental health treatment. Partnerships such as this have resulted in the creation of faith-based mental health literacy interventions that promote knowledge about mental health practices in a way that is understandable to the community. In addition to forming relationships with stakeholders in the community, collaborative partnerships should be formed with other organizations that work with youth (e.g., juvenile justice, schools) to minimize disparities in mental health across multiple systems (Caplan & Cordero, 2015).

//Conclusion

Disparities in the prevalence of mental health problems as well as in access to and outcomes of treatment exist for racial and ethnic minority youth. Lower SES, adverse childhood experiences, neighborhood stressors, and unstable family structure have all been shown to contribute independently, and interactively, to these disparities. It is important to note that safe and supportive environments and relationships can act as a buffer for youths against the harm that these risk factors impose. Practitioners should acknowledge the contributions of risk and protective factors to mental health outcomes and identify barriers that these youths may face when determining the best treatment for their clients.

Practitioners can address the mental health needs of racial and ethnic minority youth both within and outside of the clinical encounter. When working with these youths, practitioners who are culturally responsive and acknowledge the contextual factors impacting youths' mental health can help promote client engagement, which increases the likelihood of improving the clients' mental health outcomes. Practitioners can also ensure that cultural responsiveness and the adoption of a systems perspective on mental health treatment occur on the organizational level as well, so that services and processes are appropriate and beneficial to diverse clients. Collaborative partnerships—with key individuals in the community as well as with organizations that work with youths—create both local and broad networks that can facilitate access to treatment and improve mental health outcomes for racial and ethnic minority youths across multiple settings.

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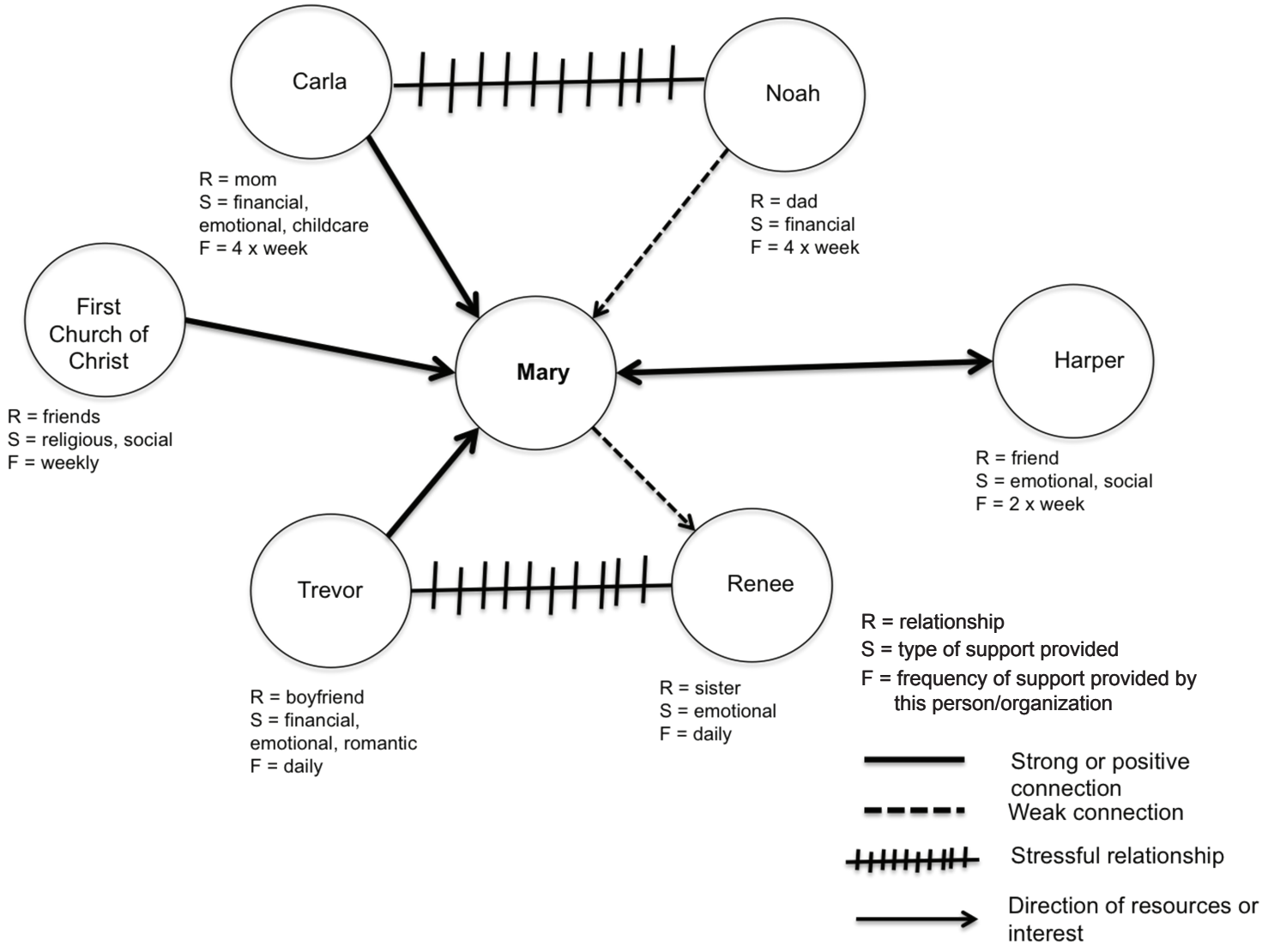
//Appendix A

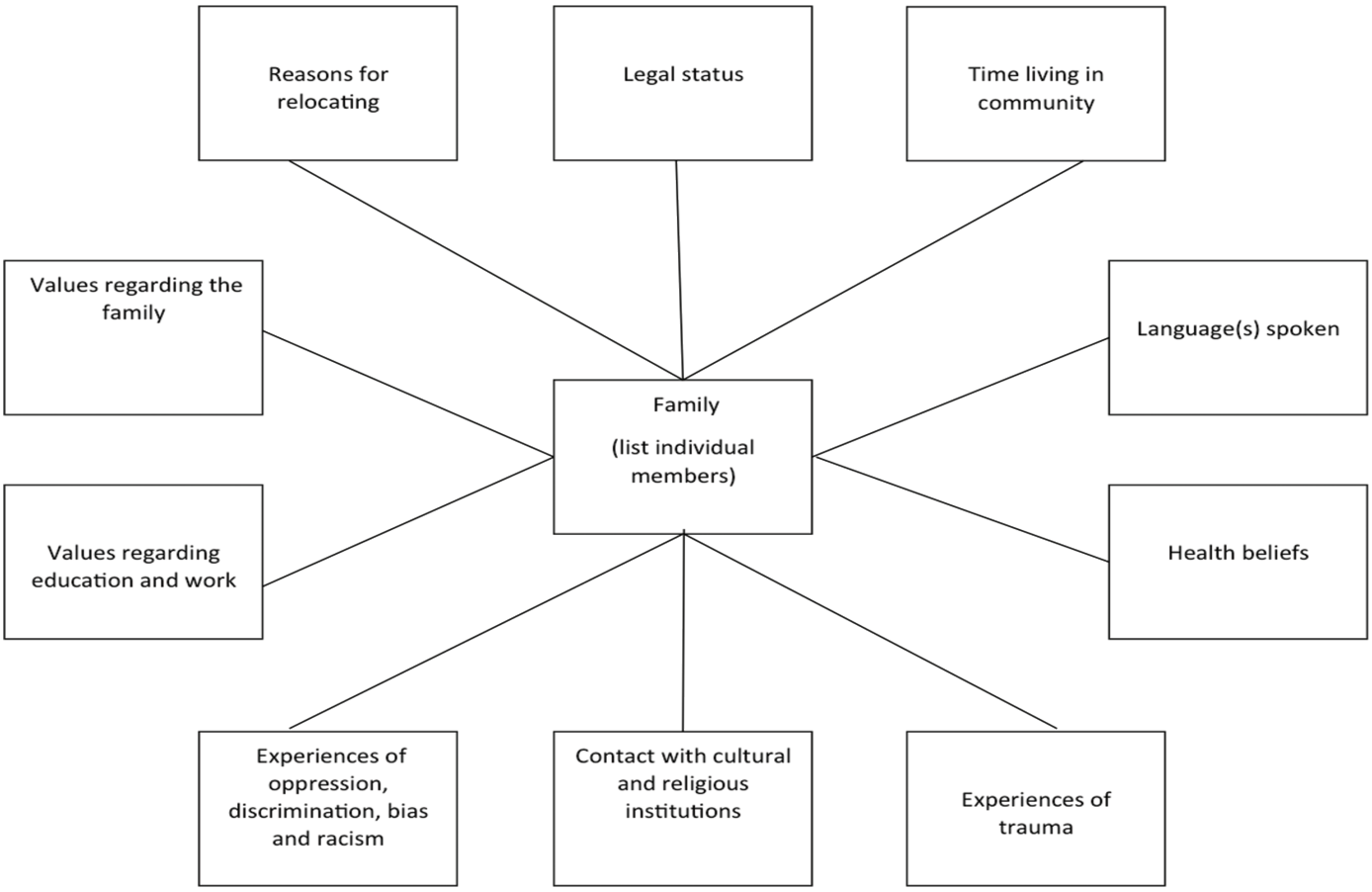
EXAMPLE OF AN ECOMAP



Note. From "Using Eco-Mapping to Understand Family Strengths and Resources" by K. M. McCormick, S. Stricklin, T. M. Nowak, & B. Rous, 2008, *Young Exceptional Children, 11*, 17–28. Copyright 2008 by Sage. Reprinted with permission.

//Appendix B

EXAMPLE OF A CULTURAGRAM



Note. Adapted from "Cultural and Ethical Issues in Working With Culturally Diverse Patients and Their Families: The Use of the Culturagram to Promote Cultural Competent Practice in Health Care Settings," by E. Congress, 2004, *Social Work in Health Care, 39*(3), p. 253. Copyright 2004 by Taylor & Francis. Adapted with permission.