Children's Mental Health Services Inequities and Potential Solutions

Andrea S. Young, PhD

Disclosures (past 3 years)

- Research support: NIH, Brain and Behavior Research Foundation.
- Board of Directors: Helping Give Away Psychological Science (HGAPS)
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Overview

- Background and History of Health Disparities
  - Contributors to Disparities and the impact of racism on health
- Review of research on racial & socioeconomic disparities in access to care using the LAMS data
- Possible Solutions
  - Research
  - Training
  - Practice

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Background

- Epidemiological studies show a high prevalence of mental health problems, but low service use among children [3,4]
- Adequate treatment is related to reduced current impairment and reduced likelihood of having mental health problems later in life

Disparities

- Community based studies show that correlates of children's outpatient service use include:
  - SES
  - Parent education
  - Family structure
  - Race and ethnicity
- Disparities in access to mental and physical health care are well-established
  - Youth of color are less likely to initiate treatment (Merikangas et al., 2010; Merikangas et al., 2011),
  - stay in treatment (Aratani & Cooper, 2012; Kapke & Gerdes, 2016; Young et al., 2016)
  - and receive adequate care (Cummings et al., 2017; Fontanella et al., 2015; Saloner et al., 2014).

The Institute of Medicine (IOM) Definition of Disparity

- Disparities in quality of and access to care: groups differences that are not due to health status or treatment preferences.

History of discrimination in mental health

Apology to People of Color for APA's Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in U.S.

Resolution adopted by the APA Council of Representatives on October 29, 2021

The American Psychological Association failed in its role leading the discipline of psychology, was complicit in contributing to systemic inequities, and hurt many through racism, racial discrimination, and denigration of people of color, thereby falling short on its mission to benefit society and improve lives. APA is profoundly sorry, accepts responsibility for, and owns the actions and inactions of APA itself, the discipline of psychology, and individual psychologists who stood as leaders for the organization and field.

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APA's Committed Actions

- Not later than August 2022, initial actions will be proposed for approval by Council, based on recommendations from members and ethnic groups, with respect to implementation of the following three priorities, though Council may offer different tactics than the examples noted below:

  - **APA will prioritize efforts in knowledge production and scholarship,** such as those that enhance psychology's scientific methods based on culturally diverse knowledge production, and those that create mechanisms to count and acknowledge all racial and ethnic groups in APA-sponsored research and membership surveys (e.g., regularly offering "AMENA" as a demographic category that survey respondents may choose, avoiding clustering small population samples, such as American Indian and Alaska Native psychologists, in "other" categories).
  - **APA will prioritize efforts in training, opening pathways, and workforce development,** such as those that expand opportunities for students of color to pursue careers in psychology; promote mentorship of psychologists of color; improve psychology graduate education and training to include diverse, non-Western cultural perspectives; increase mechanisms, strategies, and practices to raise participation and success rates for psychologists of color in academia, publishing, and governmental licensing; increase representation of communities of color throughout APA's elected and appointed leadership; expand opportunities for leadership and leadership training for psychologists of color; and enhance the visibility of psychologists of diverse backgrounds.
  - **APA will prioritize efforts in clinical practice and health equity,** such as those that elevate both advocacy for and training in culturally competent, easily accessible care models; and those that improve the discipline's knowledge of and responsiveness to the needs of communities of color. The foundational work on this has already begun, as outlined in the "Resolution on Advancing Health Equity and Psychology," developed by APA's Presidential Task Force on Psychology and Health Equity.

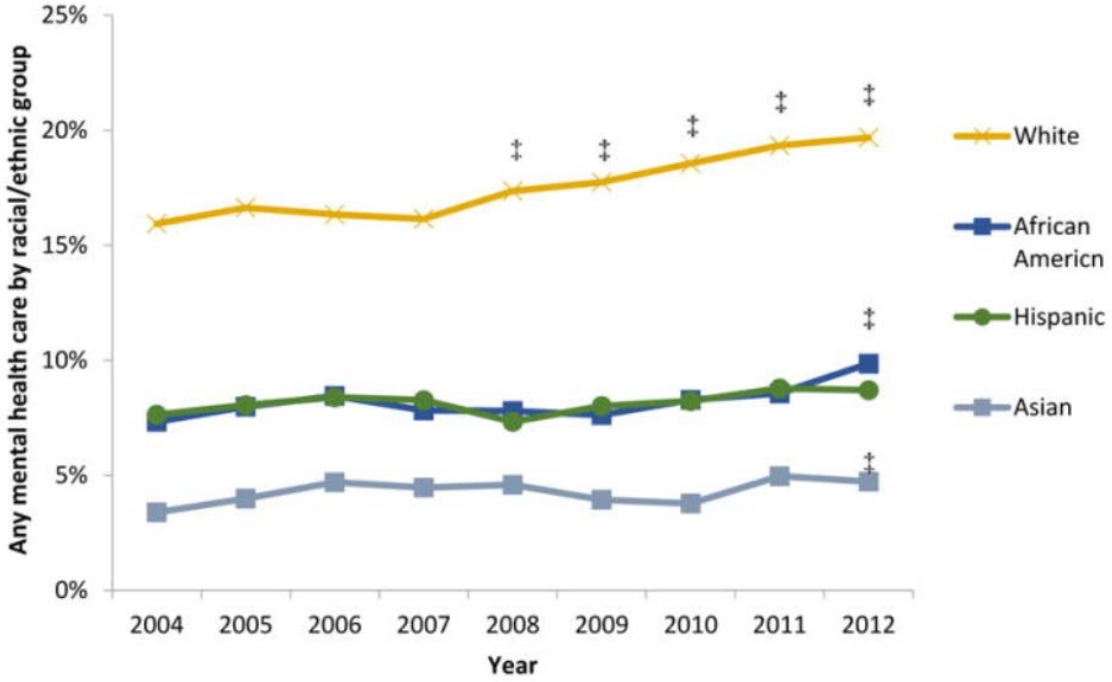
History of discrimination in mental health

January 18, 2021

APA's Apology to Black, Indigenous and People of Color for Its Support of Structural Racism in Psychiatry

Today, the American Psychiatric Association (APA), the oldest national physician association in the country, is taking an important step in addressing racism in psychiatry. The APA is beginning the process of making amends for both the direct and indirect acts of racism in psychiatry. The APA Board of Trustees (BOT) apologizes to its members, patients, their families, and the public for enabling discriminatory and prejudicial actions within the APA and racist practices in psychiatric treatment for Black, Indigenous and

Are disparities improving over time?



Cook et al., 2017

Disparities in Suicide Rates

Research Letter

FREE

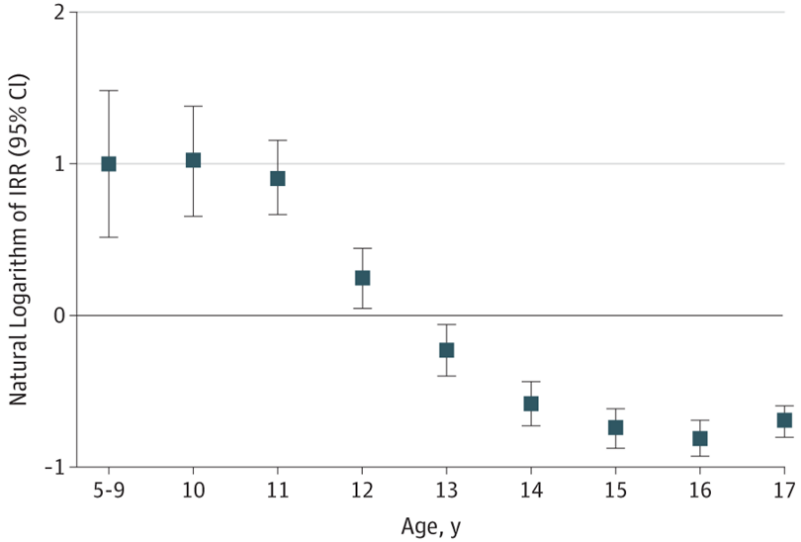
July 2018

Age-Related Racial Disparity in Suicide Rates Among US Youths From 2001 Through 2015

Jeffrey A. Bridge, PhD[1,2,3]; Lisa M. Horowitz, PhD, MPH[4]; Cynthia A. Fontanella, PhD[2]; Arielle H. Sheftall, PhD[3]; Joel Greenhouse, PhD[5]; Kelly J. Kelleher, MD[1,6]; John V. Campo, MD[2]

» Author Affiliations | Article Information

JAMA Pediatr. 2018;172(7):697-699. doi:10.1001/jamapediatrics.2018.0399

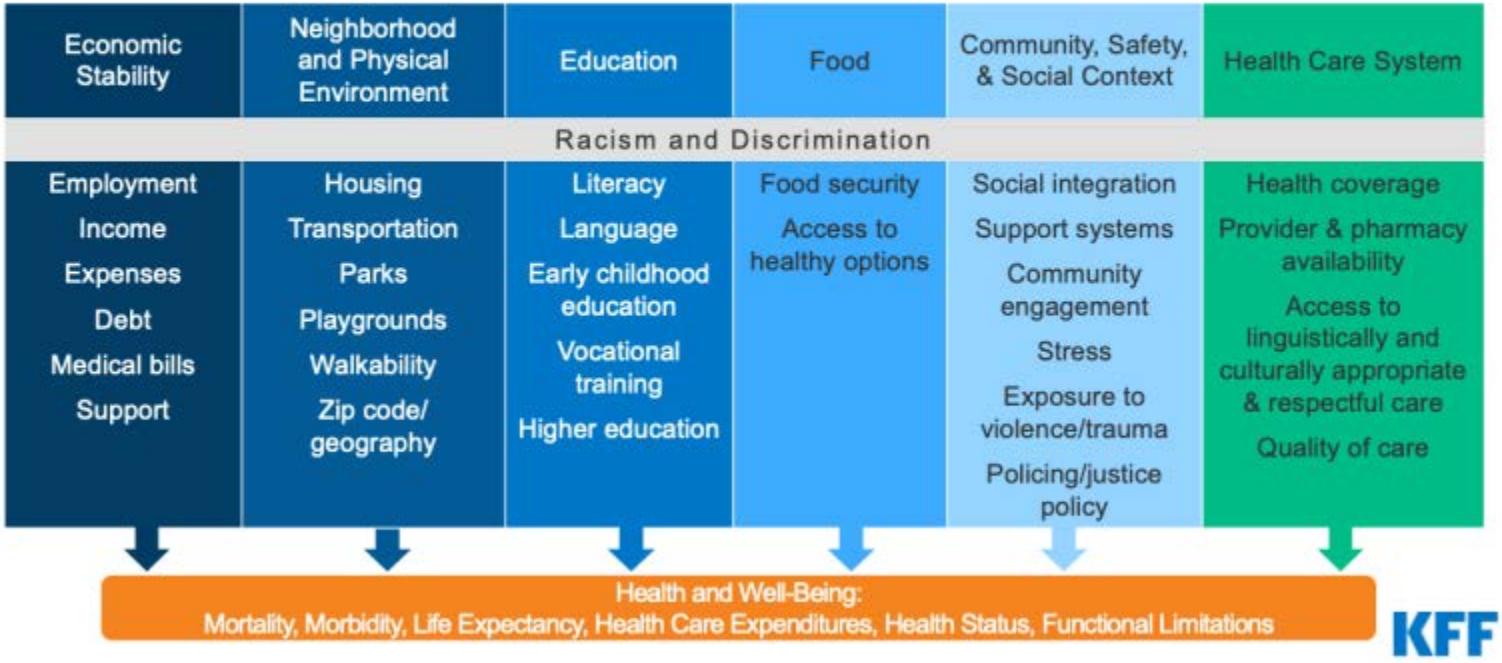


Impact of Racism on Health and Wellbeing

- Many racially minoritized youth experience racial discrimination and victimization as early as the first decade of life.
- Racial discrimination negatively impacts the health and wellbeing of minoritized youth and may create barriers to accessing care.

Figure 1

Health Disparities are Driven by Social and Economic Inequities



Contributors to Disparities

- inequitably distributed financial or logistical barriers or
- systemic barriers such as provider bias and the relatively smaller number of mental health care providers practicing in areas more populated by people from minoritized racial groups.[23-26]
- Stigma and knowledge of mental illness are frequently investigated as contributors to disparities in access to healthcare,[27] but often appear to explain only a small portion of disparities.[28]

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Longitudinal Assessment of Manic Symptoms (LAMS) Study (Findling et al. 2010)

- Naturalistic design
- **Recruited during 1st visit to 1 of the 9 outpatient clinics** associated with the LAMS partners: Case Western, Cincinnati Children's, OSU, or UPMC
- 2,622 parent-child dyads completed screening: Parent General Behavior Inventory Mania Form (PGBI-10M)
  - Exclusion criteria: autism, IQ < 70
  - Screen positive: ≥12 PGBI-10M
  - 1,111 eligible and screen+; 621 agreed to participate in longitudinal follow-up
  - 86 age and gender matched screen- also agreed
- **Longitudinal data of 707 youth (ages 6-12) assessed biannually 2005 - 2017**
- Screen-enriched for elevated symptoms of mania
- Detailed, valid, reliable methods to measure diagnoses, psychosocial functioning and child MH services use including:
  - Kiddie Schedule for Affective Disorders and Schizophrenia – Present & Lifetime
  - SACA

Objectives

- Examine possible racial/ethnic disparities in retention, identify other sociodemographic contributors and barriers to retention
- Study Questions:
  1. Do race, ethnicity, socioeconomic status, caregiver education, child diagnoses, and other child and family characteristics predict treatment over 12 months?
  2. Do parents' perception of how well the treatment matches their children's needs contribute to the prediction above and beyond child/family characteristics?

Method

- Definitions:
  - *Outpatient mental health services:* outpatient psychotherapy, medication management, or their combination
  - *Treatment retention:* continued use of baseline outpatient MH services at the 12-month interview
  - *Treatment match:* caregiver-reported match between a child's needs and the outpatient treatment the child received, rated as "not at all", "somewhat", or "very well"

Results

- 92% (n=627) were receiving outpatient medication management and/or psychotherapy at baseline
  - 33% (n=213) reported treatment match as “very well”

- 523 had complete service use data at 12 months
  - 68% (n=347) continued to use baseline services

Children's baseline characteristics associated with treatment retention at 12 month follow-up

	Model 1		Model 2	
Characteristic	Odds ratio	p	Odds ratio	p
Race (reference: white)	**.26**	**<.001**	**.24**	**<.001**
Global functioning (CGAS)	.98	.108	.97	.073
Number of diagnoses	1.17	.240	1.21	.173
Bipolar disorder (reference: absent)	1.15	.711	1.07	.868
Depressive disorder (reference: absent)	1.14	.763	1.13	.787
Parenting Stress	1.06	.071	**1.07**	**.044**
Parent perceived treatment match (reference: not at all or somewhat)			**2.31**	**.004**

No significant differences by sex, Hispanic ethnicity, age, insurance status, caregiver income or education, family structure, or type of baseline outpatient treatment.

Young et al., 2016

Conclusions

- Being a POC was significantly associated with treatment dropout even after controlling for caregiver education, income, and other clinical and demographic variables, AND after adding treatment match to the model
  - Barriers not examined in these analyses contribute to retention
- Parenting stress findings are consistent with previous research that greater parent burden is associated with increased service use
- Parents' attitudes early in treatment (match between parents' expectancies of treatment and the execution of the treatment) are important indicators of likelihood to continue treatment

Implications

- Even families who overcome barriers to initiate treatment face further barriers to continued service use
- Clinicians should:
  - Be sensitive to parents' opinions and cultural differences that may affect engagement (cultural humility)
  - Carefully assess families' treatment barriers early in treatment
  - Discuss treatment plans with parents, incorporate parents' opinions into treatment plan when appropriate, explain rationale for selected treatment modalities, offer a choice of treatments

“Adequate care”

Minimally Adequate Treatment	Expert Consensus
≥ 4 mental health visits (with any mental health care provider) + medication OR eight visits without medication No adjustments for clinical characteristics (eg, comorbidity, severity)	Consider appropriateness of different medication therapies and the comprehensiveness of care, given a child’s profile of comorbidities Based on recently published practice guidelines/recommendations Independent ratings by two licensed clinicians; consensus meeting to discuss discrepant ratings

Adequate Care

Collapsed Rating for Analysis	Treatment Rating	Definition
Adequate	Standard of care	Treatment is consistent with treatment guidelines without clear evidence of missing components
	Adequate	Treatment for the primary diagnosis is consistent with treatment guidelines AND secondary/less severe diagnosis is partially treated with no inappropriate/contraindicated treatment; partial treatment received for an NOS diagnosis
Inadequate/ Inappropriate	Inadequate	An indicated treatment component is missing
	Inappropriate	At least one component of the treatment provided is contraindicated; polypharmacy that is not consistent with treatment guidelines
	Treatment pending	Treatment is indicated and there is evidence that it is forthcoming but has not yet begun

Participant characteristics by group

Variable	Standard of Care/Adequate (n=364)	Inadequate / Inappropriate / Treatment Pending (n=323)	p-value for comparison
Sex			
Female	111 (30.5%)	112 (34.7%)	0.277
Male	253 (69.5%)	211 (65.3%)	
Race			
Black	71 (19.5%)	102 (31.6%)	0.001
AIAN, Asian, biracial	47 (12.9%)	36 (11.1%)	
White	246 (67.6%)	185 (57.3%)	
Age (years)[a]	9.37 (1.85)	9.44 (2.02)	0.634
Insurance			
Medicaid	177 (48.6%)	181 (56.0%)	0.052
Other Insurance	187 (51.4%)	142 (44.0%)	
Caregiver Education			
Less than Bachelors	283 (77.7%)	276 (85.4%)	0.013
Bachelors or greater	81 (22.3%)	47 (14.6%)	
CGAS Score[a]	55.35 (10.93)	53.80 (9.57)	0.048
Any ADHD Diagnosis	262 (72.0%)	261 (80.8%)	0.009
Any BPSD Diagnosis	71 (19.5%)	82 (25.4%)	0.079
Any PDD Diagnosis	33 (9.1%)	11 (3.4%)	0.004
Any Psychotic Diagnosis	14 (3.8%)	4 (1.2%)	0.058
Any Anxiety Diagnosis	102 (28.0%)	117 (36.2%)	0.026
Any DBD Diagnosis	177 (48.6%)	177 (54.8%)	0.124
Any Depressive Diagnosis	55 (15.1%)	66 (20.4%)	0.084

Results of logistic regression models

Variable	Demographic Characteristics Only (df=6)		Demographic Characteristics and Diagnoses (df=16)	
	OR	95% CI	OR	95% CI
Sex				
Female	1.23	0.82, 1.86	1.23	0.81, 1.86
Male	ref.	ref.	ref.	ref.
Race				
African American/Black	1.76	1.47, 2.10	2.03	1.53, 2.70
AIAN, Asian, multiracial	0.96	0.88, 1.06	1.00	0.85, 1.17
White	ref.	ref.	ref.	ref.
Age (years)[a]	1.01	0.90, 1.14	1.02	0.89, 1.16
Insurance				
Medicaid	1.03	0.74, 1.44	0.95	0.61, 1.47
Other Insurance	ref.	ref.	ref.	ref.
Education				
Bachelors or greater	0.68	0.56, 0.82	0.71	0.60, 0.83
Less than Bachelors	ref.	ref.	ref.	ref.
CGAS Score	–	–	0.99	0.98, 1.00
Any ADHD Diagnosis	–	–	1.53	0.90, 2.61
Any BPSD Diagnosis	–	–	1.48	0.81, 2.73
Any Anxiety Diagnosis	–	–	1.57	1.10, 2.24
Any DBD Diagnosis	–	–	1.01	0.62, 1.65
Any Depressive Diagnosis	–	–	1.35	0.71, 2.56

Implications

- Only 53% had received adequate medication for their diagnoses
- Youth whose caregivers had a bachelor's degree or more education were most likely to receive adequate care, consistent with prior research
- Youth with anxiety were less likely to receive adequate care
- Also consistent with our hypotheses, Black youth were less likely than White youth to receive adequate care. White youth and youth who identified as American Indian, Asian, or bi/multiracial did not significantly differ in likelihood of receiving adequate care.
  - Persisted with adjustments for Medicaid status, caregiver education, and clinical characteristics
  - racial disparities in access to mental health care are well-established and may originate from inequitably distributed financial or logistical barriers, systemic barriers

Next steps

- Examine prospective associations between receiving adequate care and psychosocial outcomes (do disparities in access lead to disparities in outcome)
  - Academic and social functioning,
  - psychiatric hospitalization
  - Substance use
- Identify strategies to improve youths' access to quality mental health services

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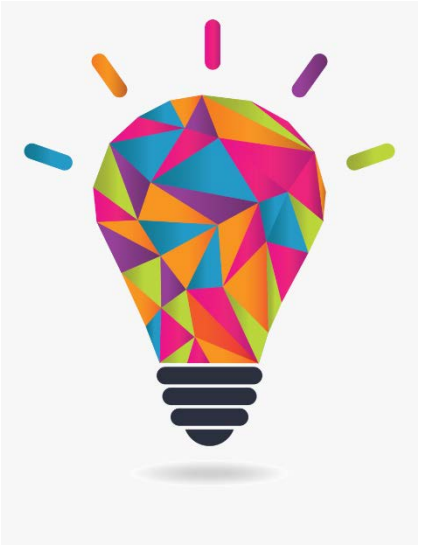


Policy Changes

- Make treatment more affordable
- Increase access to insurance
- Incentivize mental health practice in underserved areas

Evidence-based Practices

- Potential reason for racial/ethnic disparities in treatment outcomes → RCT samples
  - Predominately white, middle-class
  - For whom are practices evidence-based?

Cultural adaptations

- Culturally-adapted versions of evidence-based treatments (EBTs) have been developed to help address this treatment gap.
- Some culturally adapted interventions have shown benefit over the traditional EBTs or WLC (Hall et al., 2016),
- Others have found mixed results with no treatments being well-established for racially minoritized youth (Huey & Polo, 2008; Sanchez et al, 2021)

Person-centered Approaches

Cultural Definition of the Problem
• Definition of the problem as described by patient • How the patient would describe their problem to their family/social network • What matters most to the patient about their problem
Cultural Perceptions of Cause, Context, and Support
Causes • Causes as described by patient • Causes as described by patient's family/social network
Stressors and Supports • Stressors (e.g., immigration, racism, discrimination, housing/food insecurity, community violence, problems with family) • Current supports and coping (e.g., family, religion and spirituality, community involvement, activism)
Role of cultural identity • Most important aspects of background or identity, or family values (e.g., groups/communities they belong to, racial ethnic background, where they are from, gender or sexual orientation, religion spirituality, family closeness or other things that are important to them) • Aspects of their identity that makes the problem better or worse • Other difficulties related to background or identity (e.g., immigration related problems, conflict across generation due to difference in values)
Cultural Factors Affecting Self-Coping and Past Help Seeking
Self-coping • Current coping strategies
Past help seeking • Experiences with help seeking and its usefulness (e.g., medical care, mental health treatment, support groups, informal counseling, folk healing, religious or spiritual counseling, talking with a member of their community, other forms of traditional or alternative healing)
Barriers • Help seeking (e.g., language, cost, transportation, discrimination, stigma)
Cultural Factors Affecting Current Help Seeking
Preferences • Patient therapy preferences • Family member/members of their social network's recommendations
Clinician-Patient Relationship • Past experiences with providers, possible concerns (e.g., structural/interpersonal racism, language barriers, communication) • Potential concerns with current services or how to prevent them (e.g., addressing previous communication issues)

Person-Centered Approaches

EVIDENCE BASE UPDATE

Person-Centered Cultural Assessment Can Improve Child Mental Health Service Engagement and Outcomes

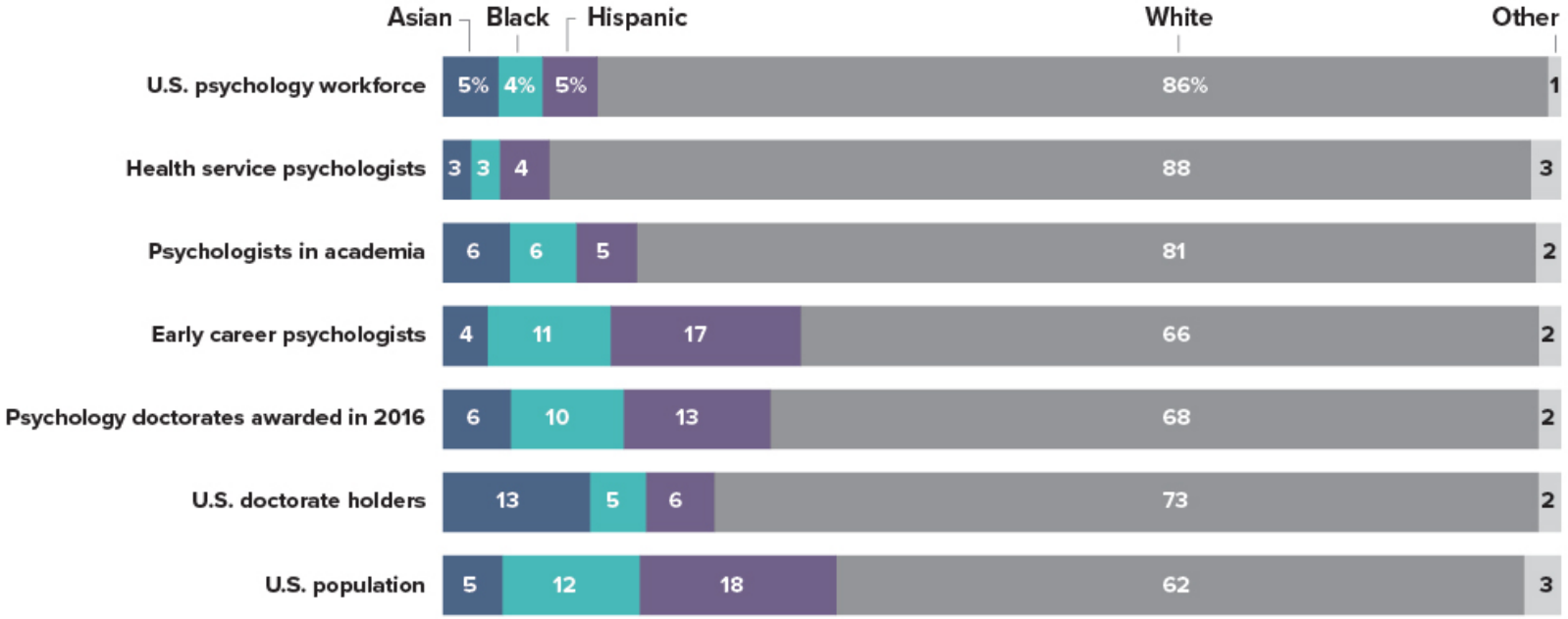
Amanda L. Sanchez, Jason Jent, Neil Krishan Aggarwal, Denise Chavira, Stefany Coxe, Dainelys Garcia, Martin La Roche & Jonathan S. Comer ...show less

Pages 1-22 | Published online: 14 Dec 2021

Increase Diversity of Study Populations

- Intentionality in recruiting and retaining participants from underserved populations

Increase Workforce Diversity



Why is Workforce Diversity Important?

- There is evidence of provider bias influencing clinical decision-making (Chapman et al., 2013; Merino et al., 2018).
- Mental health treatment may be more susceptible to provider bias as decisions about treatment access, diagnosis, and disposition are often made by a single provider, compared the team-based approaches of many other disciplines (Merino et al., 2018).
- Black providers are less likely to display racial bias (Chapman et al., 2013)

Increase Workforce Diversity

Increase Workforce Diversity

Special Issue: Advancing Racial Justice in Clinical Child and Adolescent Psychology; *JCCAP*

- The issue will focus on three areas that hold the potential to reduce inequitable treatment of children and adolescents of color in our field:
  1) strategies to address structural barriers that disproportionately impact youth of color,
  2) approaches to increase representation of mental health care providers of color, and
  3) providing culturally responsive care.
- Stay tuned.

Noelle Hurd, PhD, UVA

THANK YOU!

Questions?

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