



## Youth Clinical Outcomes: Does Race/Ethnicity Matter?



Artwork by Julia Chang, age 10

A growing emphasis on cultural competence in children's mental health has increased our awareness of the need to tailor interventions and service delivery approaches to make them appropriate for children, youth, and families from different cultural groups. When we evaluate services and service systems, we are therefore interested in seeing whether or not they demonstrate an acceptable level of cultural competence. One of the ways that this is often done is by examining clinical outcomes in an effort to determine whether children and youth from different races or ethnic groups appear to be benefiting from services. However, there are a number of difficulties and complexities involved in using outcome data in this way. This article explores some of this complexity, and uses data from a study of mental health outcomes to illustrate what standardized outcomes measures can—and can not—tell us about whether services are effective for children from different cultures.

Although the investigation of racial/ethnic differences in mental health outcomes is often impeded by the need for large samples of services users, such examinations may be possible in conjunction with the many quality improvement efforts being put into place to assess youth outcomes in public sector mental health services across the nation. Mental health performance evaluation programs are increasingly encouraged in order to assess the effectiveness of service systems. To this end, service systems have implemented large-scale data collection procedures for evaluating youth outcomes. These evaluations often include county or multi-county community service systems and therefore provide large amounts of data that can be used to analyze youth outcomes comparatively. These systematic efforts are important for identifying factors such as client race/ethnicity that may or may not be associated with improved youth outcomes.

These initiatives are heartening for the field of mental health but they may also be a source of some concern. Pressures for accountability may force the process of program evaluation to progress quickly, and with limited information on the appropriateness of evaluation tools and procedures across services for diverse populations. Standardized outcome assessment protocols are mandated in many public and private mental health systems, and the results of such protocols may be used to influence funding and service delivery decisions. Consequently, it is extremely important to understand factors such as race/ethnicity that may be related to reported change on clinical outcomes.

To set the stage for interpreting differences in youth outcomes by race/ethnicity in mental health services, let us examine two related issues: 1) multiple informant reports and 2) utilization of services.

Research on the first issue, multiple informant reports, has found that clinician, parent, and youth reports on assessments may differ significantly. Each informant's report appears to represent a unique and independent perspective, and low correlations between clinicians, parents, and children/youth are not simply due to differences in situations (Phares, Compas & Howell, 1989; Kazdin, Esveltd-Dawson, Unis & Rancurello, 1993). Different informants may actually be reporting on different types of problems or behaviors. It has been suggested that measuring child psychopathology involves studying both the behavior of children *and* the lens through which adults view child behavior. In other words, it is important to understand the perceptions, attitudes, and beliefs that lead adults to regard some forms of child behavior as problematic or pathological (Weisz, McCarty, Eastman, Chaiyasit & Suwanlert, 1997). How adults view child behavior may be heavily influenced by ethnicity and, more specifically, by culture. Cultures may differ markedly in terms of the specific problems for which

children tend to be referred to mental health specialists (Weisz et al, 1987). Parents of various cultures appear to have different “adult distress threshold” levels (Weisz, 1989). This means that what parents from one culture perceive as problematic behaviors or symptoms requiring professional attention may not be perceived in the same fashion by parents from another culture. It remains unknown, however, whether observed ethnic differences result from actual syndrome experiences or from cultural variability in the expression, manifestation, and reporting of problems (Good & Kleinman, 1985; Gibbs & Huang, 1989). In sum, reports of youth impairment are probably amalgams of actual behavior, perceptions, beliefs, and threshold levels, all of which may be influenced by the reporter’s culture. Therefore, when examining racial/ethnic differences in clinical outcomes, it is advantageous or even critical to consider reports from multiple informants.

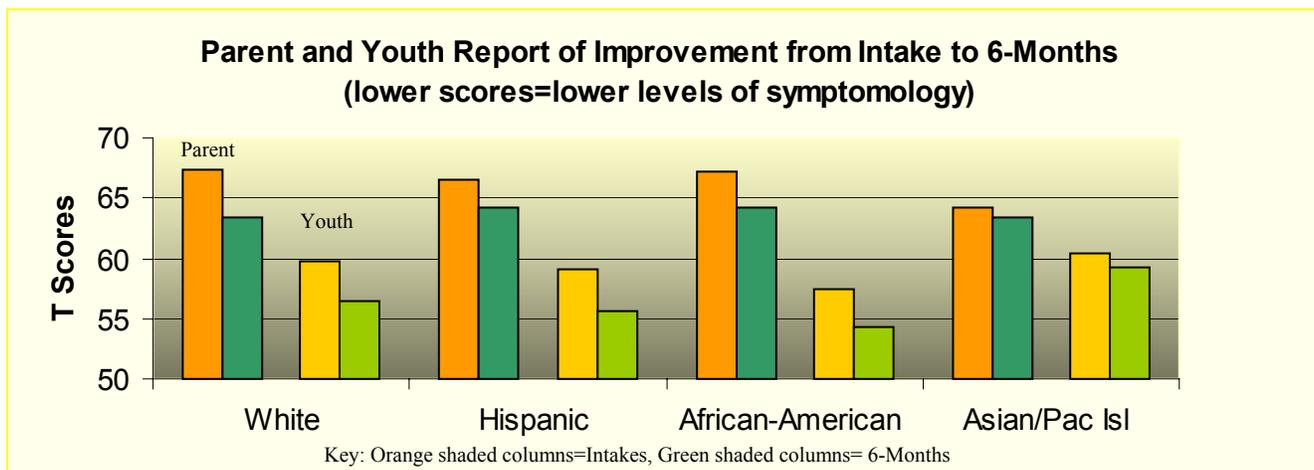
Secondly, race/ethnicity has been found to be a significant factor in utilization of services, even after controlling for level of symptomatology. While inconsistencies in identifying utilization trends-do occur, it appears that Asian American/Pacific Islanders use outpatient and inpatient services at much lower rates than what would be expected based on their population. African-American/Blacks appear to utilize services at a higher rate than expected. Native Americans/Alaska Natives appear to use services equivalent to their population, and there are mixed findings for Latinos/Hispanics (Breux & Ryujin, 1999; Bui & Takeuchi, 1992; McCabe, Yeh, Hough, Landsverk, Hurlburt, Culver & Reynolds, 1999; Pumariaga, Holzer & Nguyen, 1993). These rates are determined by comparing an ethnic group’s representation in a population to the proportion of usage in that population by race/ethnicity. Since the rates are determined by representation in any given population subgroup, utilization rates may vary by

national, regional, or local patterns. Other confounding factors in utilization rates include the effects of education, income, age and level of acculturation, each of which may be associated with race/ethnicity. Racial/ethnic differences in service utilization rates have implications for interpreting service outcomes, as the sample of service-users may not be representative of all children actually in need of care.

### An Examination of Outcome Differences

Now, let us examine the data collected through a mandated evaluation program that used standardized assessments of youth mental health outcomes to evaluate services in a large metropolitan community in California. Of interest are the following questions: Do all race/ethnic youth clients improve after participating in community based mental health outpatient services? Do all ethnic groups fare equally well when compared to each other after treatment? Do different types of informants rate improvements similarly across different racial/ethnic groups?

The study sample included 1,412 youth ranging in age from 3-18 years old who received services in a public mental health outpatient clinic in a California community for at least 6 months within the years of 1997 to 2001. The average age of the youth in service was 11 years. Two thirds of the youth were male (63%) and the racial/ethnic distribution was as follows: 35% Caucasian, 47% Hispanic, 13% African-American, and 5% Asian American/Pacific Islander. (Population distributions are 47% Caucasian, 37% Hispanics, 7% African-American and 10% Asian/PI.) The Asian American/Pacific Islander youth differed descriptively from the other groups, as these youth were half male and half female and were older, with an average age of 14.



The data was analyzed for differences on change in clinical outcomes after six months of community mental health outpatient services. Standardized clinical measures were completed by multiple informants: clinician, parent, and youth. Measures assessed levels of youth impairment and symptomatology. Clinicians reported on youth functioning by completing the Child and Adolescent Functional Assessment Scale (CAFAS, Hodges & Wong, 1996). Parents reported on youth symptomatology by completing the Child Behavior Checklist (CBCL, Achenbach, 1991) and youth (aged 11 or older) reported on their own symptoms by completing the Youth Self Report (YSR; Achenbach, 1991, a companion measure to the CBCL).

*Do ethnic minority youth clients improve after participating in community based mental health outpatient services?* To address this first question, the data collected at intake into services was compared to the data collected at six months after services for each race/ethnic group. The data revealed that youth from the four race/ethnic groups entered services with similar levels of symptoms and impairments. There were no statistically significant differences between the groups across informants, but there was a trend for clinicians to report Hispanic youth as less impaired and parents of Asian/Pacific Islander youth to report less severe levels of symptoms compared to youth of the other groups. Only three of the four race/ethnic groups reported significant levels of improvements from all three informants (clinician, parent and youth) after six months of mental health services. Asian American/Pacific Islander youth and parents did not report improvements, whereas the clinicians treating these youth did report improvements.

*Do all ethnic groups fare equally well after treatment?* To address this question, regression analyses (controlling for age, gender, and impairment level) were used to compare the improvements across the four races/ethnic groups. These analyses revealed answers to the third question as well: Do different types of informants rate improvements similarly across different racial/ethnic groups? According to our results, clinicians report that Asian American/Pacific Islander youth improve the most, significantly more than youth of other races/ethnic groups. This appears to contradict the finding that parents of these youth report no improvement after services. Parents of White youth report their children as making significantly larger improvements than other youth. Clinicians report Hispanic youth as less impaired yet improving similarly to other groups. Lastly, a main effect for informant was evident revealing that youth, overall, report less symptomatology than parents and clinicians.

The results indicate both a race/ethnicity effect and an informant effect; however our analyses cannot answer many questions raised by the data. It remains unclear if the differences in reported outcomes by clinicians, parents and youth are more related to: 1) measurement error of outcomes assessment, 2) different cultural interpretations or expectations of symptoms severity, or 3) true behavioral disparities. What is clear is that administrators, researchers, and clinicians alike should be cautious of making service delivery decisions based on aggregated information across race/ethnicities and/or from a single perspective. It is also clear that we need to learn more about how race/ethnicity and culture are related to outcome measurement and to outcome differences. Research on measurement error is needed to tease out the possible influencing factors such as language, beliefs, and customs that can produce different understandings of questions used to assess client outcomes. Research on acculturation, values, treatment expectations, and change mechanisms is needed to further define the different cultural interpretations of symptom severity and improvement. Finally, research is needed that further defines the family, therapist, and situational characteristics that are associated with treatment progress and positive outcomes between and across various race/ethnic groups.

Like other studies on similar topics, our evaluation study has several limitations that further complicate interpretation of the results. First, the race/ethnic groupings were "panethnic," meaning that all members identifying from a large class of people, such as Asians, were classified together without measurement of acculturation level or cultural beliefs. Second, the parents and youth reported on youth symptomatology, whereas, the clinicians reported on youth functional impairment. Although symptomatology and functional impairment are related and diagnoses include problematic levels of both, the results of the data may be affected by the measurement equivalence issues. Last, information regarding treatment process is unavailable. It is unknown if a certain race/ethnic group received treatment elements that differed from those received by another. What is known is that youth from all subgroups participated in community outpatient clinics (typically in their home neighborhoods) and that services were provided in their language of choice by clinicians trained in cultural competence issues (and often of similar race/ethnicity as clients).

In sum, our study provides an illustration of how much we have yet to learn about why race/ethnicity is associated with varying rates of service utilization and with differences in outcomes on standardized measures.

To better understand this issue, we will need to develop a more sophisticated understanding of how particular beliefs, behaviors, and values come into play as people access and receive services and as they evaluate symptomology and outcomes. With this sort of knowledge we can achieve improvements in the quality of mental health care for all youth.

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