DATA TRENDS

DISPARITIES IN TREATMENT FOR SUBSTANCE USE DISORDERS AND CO-OCCURRING DISORDERS IN ETHNIC/ RACIAL MINORITY YOUTH

SOURCE

Alegria, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/ racial minority youth. *Journal of the American Academy of Child & Adolescent Psychiatry, 50*(1), 22-31.

Youth who have substance use disorders (SUD) and co-occurring disorders (COD) experience increased difficulty reaching educational, employment, and social goals. Yet some populations experience disparities – differences, such as socio-economic status (SES) or insurance, that cannot be justified by health conditions or treatment preferences – in seeking care for these conditions. For example, it has been demonstrated that ethnic and racial minority youth experience disparities in access to needed SUD/ COD treatment and in overall quality of treatment compared to non-Hispanic White youth.[1] Such disparities may be a result of a number of issues, including health care policies and procedures; how referral and treatment organizations are structured; availability of providers; a lack of culturally appropriate treatment; and historical discrimination against ethnic and racial minority members. This study reviewed literature on racial/ ethnic disparities in behavioral health services for youth in the United States.

METHOD

Alegria and colleagues searched the literature for studies that directly addressed racial/ ethnic differences in behavioral health services for children or adolescents. Literature search sources included PubMed, PsychInfo, Center for Substance Abuse Research, The National Survey on Drug Use and Health, and the National Institute on Drug Abuse-funded Monitoring the Future. Search terms used were: substance use disorders, health services, adolescence, health disparities, ethnicity, poverty, and service disparities. The literature was organized under six categories: 1) federal and economic health care policies and regulations; 2) operation of health care and school-based systems and provider organizations; 3) provider level factors; 4) the environmental context including social and economic forces; 5) the operation of the community system; and 6) patient level factors.

RESULTS

Compared to non-Hispanic Whites, African American adolescents with SUD report seeing specialists less often and also report receiving less

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informal care (i.e., care from family members or other non-professionals) for SUD and COD and Latinos with SUD report fewer informal services for SUD and COD. The authors note many factors and processes leading to these disparities.

Federal and Economic Health Care Policies and Regulations: More than 60% of uninsured children are African American or Hispanic and three fourths of the uninsured are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). The authors note that since SCHIP increases access to SUD and COD services for minority youth, state and federal health care policies that restrict access to this program may result in healthcare access disparities. Determining ways to increase enrollment in SCHIP among racial/ ethnic children can result in a reduction in racial/ ethnic disparities in meeting behavioral health needs.

Operation of Health Care and School-based Systems and Provider Organizations: Overall, research has found that racial/ ethnic minority youth with behavioral health needs are under-identified by schools although the results of studies vary in terms of whether teachers differ in referral to treatment. Racial/ ethnic minority members also tend to receive less intensive COD treatment when behavioral challenges are indicated, which can result in lower quality of services. It may be that clinicians misidentify treatment need for some subpopulations.

Provider Level Factors: A shortage of healthcare providers is four times as likely in communities with high proportions of African American and Hispanic persons regardless of community income. Additionally, the authors found that unavailability of multilingual providers for diverse communities can lead to misinterpretations of needs and SUD and COD conditions, resulting in low treatment retention. The authors also note that provider attitudes that do not consider social contexts of marginalization, discrimination, and poverty can lead to misinterpretation of difficulties in treatment engagement and will likely result in low quality care.

The Environmental Context, including Social and Economic Forces: Youth in need of care are less likely to be identified for treatment when they live in communities with higher proportions of single-parent families, increased rates of drug-related arrests, and higher proportions of racial/ ethnic minority residents. Youth are more likely to be identified as being in need when they live in communities with higher average income, greater proportion of persons who graduated from high school, and greater concentrations of treatment facilities. The review found that American Indians and Alaska Natives are particularly underserved with regard to behavioral healthcare.

The Operation of the Community System: The authors found that healthcare disparities were affected by family, friends and the lay sectors within the community. Long-standing barriers to care for communities of color may have led families to develop a tolerance of suffering and formal care may not be sought until children exhibit pronounced difficulties. Fear of coercive treatment based on historical events and collective memory, may be another barrier. A provider's lack of consideration of cultural values, and assessment models that are insensitive to culturally-specific issues may lead to family dissatisfaction with treatment. When parents contend with multiple stressors and competing

demands, ability to support engagement in treatment is limited. Low healthcare literacy may also result in underuse of insurance benefits and poor understanding of treatment protocols, which may lead to lower adherence to treatment plans.

Patient Level Factors: Racial/ ethnic minority youth may prefer individual treatment over group services as increased privacy offers safety for self-disclosure and avoidance of stereotyping. Formal measures for assessing behavioral health conditions may require further validation among various racial/ ethnic groups in order to improve accuracy of need detection. While up to 80% of youth in substance abuse treatment have co-morbid mental disorders, different racial/ ethnic subpopulations exhibit different patterns of co-morbidity. The review found that African American, Hispanic, and mixed-race youth are more likely than White youth to have internalizing conditions such as depression and posttraumatic stress disorders. African American and American Indian/ Alaskan Native youth are less likely than their White counterparts to have externalizing problems such as conduct issues or both internalizing and externalizing problems. These different patterns influence use of services, which may not be designed with these variations in mind.

CONCLUSION

The authors conclude that barriers to quality SUD and COD treatment are significant issues for racial/ ethnic minority youth. Disparities could be reduced by adoption of state policies that increase insurance eligibility; increase screening in communities with higher rates of diversity and/ or lower SES; target provider attitudes regarding the social context of discrimination and poverty; and address health literacy. Addressing direct service issues would require culturally appropriate screenings and treatment adaptations that take into consideration the social and behavioral characteristics of various populations as well as factors that influence health behaviors. Culturally validated measures of treatment need would include variables related to discrimination, ethnic orientation, ethnic mistrust, acculturation, and acculturative stress. Providing care in the native language of patients and addressing parental beliefs regarding needs and services could increase treatment engagement. Some families may fear discrimination, inappropriate care and/ or treatment coercion and turn to self-reliance instead of more formal care, while others may be contending with highly demanding lives that limit ability to support treatment engagement. Further research should focus on how youth and families are dissuaded from service use. Communities that face social exclusion should not have to depend solely on self-reliance and informal help, but should instead be offered competent care for their youth.

REFERENCES

1. Institute of Medicine. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, D.C.: The National Academies Press.

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