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One Size Does Not Fit All: Taking Diversity, Culture and Context Seriously

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Abstract Evidence suggests that the current mental health system is failing in the provision of quality mental health care for diverse children and families. This paper discusses one critical domain missing to improve care: serious attention given to diversity, culture, and context. It discusses what we mean by understanding culture and context at the individual, family, organizational, and societal level. Focusing on key predictors of children's adjustment in natural contexts would increase attention to building community and family capacities that strengthen children's mental health. To conclude, we suggest changes in organizational culture to build natural supports to enhance children's mental health.

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Introduction

In today's progressively global world, professional health and mental health care providers are increasingly required to interact with families whose race, culture, national origin, living circumstances, and family composition are different from their own. This is particularly true in almost any urban clinic in the U.S., but especially so in public contexts, where providers routinely encounter multiethnic and multiracial populations. By the year 2010, immigrant children will comprise 22% of school age children in the U.S. (Connect for Kids 2006). In contrast to immigrants from Europe during the 19th century, most families that immigrated to the United States in the last two decades have come from Latin America, the Caribbean, Asia, and Africa (Singer 2002). These children and families speak different languages and often have skin color that distinguishes them from the European (majority) culture. According to the National Survey of Children's Health of 2004, the primary language spoken at home was far more likely not be English in Latino (60%) and Asian/Pacific Islander (41%) households compared with white (1%) children's households (Flores and Tomany-Korman 2008).

These populations include families whose notions of mental disorders are totally dissimilar from that of the clinician in charge of making decisions about their care. Mental illnesses (e.g. defined as any current or past year psychiatric disorders that result in functional impairment which substantially interfere with the child's role or functioning in family, school or community activities) in certain cultures can be largely thought to be completely

incurable, or at least unresponsive to modern medical practices (Desjarlais 1995; Gureje and Alem 2000). In Latin America, deeply rooted cultural beliefs can lead to feelings of guilt and shame, distorted help-seeking patterns, and religious or folk beliefs about the origins of mental disorders (Alarcón 2003), ideas reported by immigrants coming to the UK (Cinnirella and Loewenthal 1999) and the US (Cauce et al. 2002). Among some immigrant families, there is a great reluctance or delay in seeking appropriate mental health services, even when health-damaging responses to mental illness can occur (Gureje and Alem 2000; Razali et al. 1996; Whyte 1991). Often times, Western medicine is not considered to be the preferred treatment for mental disorders in these countries (Alem et al. 1999; Saeed et al. 2000).

Moreover, ethnic and racial minority families from the US may also differ in their explanations about mental illness and treatment (Novins et al. 1997), sometimes based on the types of services they historically had available and not necessarily due to an alternative conception of illness causation (Kirmayer et al. 2003). For example, African American and Native American families may have alternative explanations of mental illness such as supernatural or spiritual forces that lead youth to undesirable behaviors (Cheung and Snowden 1990). Ideas of coping with mental illness may also vary, with African American youth sometimes being encouraged to use will power to "tough out" situations (Browman 1996) or Asian American youth being advised to not dwell on uncomfortable thoughts (Cheng et al. 1993).

We know that disorder, disease, and healing may manifest differently in different *cultures* (Kleinman et al. 2006). The decision to use medications (Snowden and Yamada 2004) and help-seeking behaviors (Snowden and Yamada 2004) are partly driven by culture. We also know that some children can be misdiagnosed because screening instruments and diagnostic criteria are often developed by (and for) the majority culture; that is, the culture of the majority of providers and health systems, not necessarily of the majority of the population in many communities (Dressler and Badger 1985; Huang et al. 2006; Vega and Rumbaut 1991). These facts suggest that cultural differences may play a critical role in the individual's recognition of mental illness and the provider's detection of the mental illness including the perception and intensity of stigma associated with mental health help-seeking behavior and the understanding of what might be considered mental health disorder requiring appropriate mental health services.

Multicultural groups are diverse not only in their beliefs and expectations, but also in their assumptions about what the clinician can do for them (Katz and Alegría 2009). Individuals seeking help may possess diverse views of what matters most to them as compared to the provider, which may result in a lack of shared problem definition between the individual and the provider (Suurmond and Seeleman 2006), increasing the potential for misaligned treatment approaches.

Similarly, changing family structures and the diverse context of childrearing may be challenging for clinicians whose personal experience with family and neighborhood is very different from those of their diverse multicultural clients (Burkard et al. 1999). Children and youth today live in varied family arrangements and contextual environments, each with its own distinct cultural milieu. For example, 26% of US children in 2000 resided in single-parent households and 15% lived in blended families (Kreider and Fields 2005), signaling a significant shift in the living arrangements of children since the 1970s. Children live in the context of their families—even those who are in foster care, institutionalized, or otherwise physically separated from their original families—and their communities. For too many this context also includes involvement with child welfare and the juvenile justice system (Freudenberg and Ruglis 2007; Lauritsen 2005). Consequently, the context in which these families live, and even the definition of families, has been dramatically altered in the last three decades.

Yet, the context of childrearing has a profound impact on well being and risk for illness. A child's resilience is dependent upon numerous contextual factors, not the least of which includes a reliable and supportive adult who cares about them (Cicchetti and Rizley 2006; Oades-Sese and Esquivel 2006). There is noteworthy cross-cultural work (Draper and Harpending 1982) suggesting that children might be particularly reactive and susceptible to the context of early childrearing that is closely linked to their living arrangements. Childrearing differences also appear to influence the child's prospective bonding and psychological development. The development of optimal behavioral strategies, thus, appears dependent on the social and physical environmental cues that regulate interpersonal and behavioral development (Belsky et al. 1991) in these contexts. These cues vary by the childrearing patterns occurring in different family arrangements.

Because children spend a significant portion of time outside their homes, neighborhoods and schools also play a critical role in their mental health outcomes. Furstenberg's ethnographic studies (Furstenberg and Hughes 1997) pinpointed how families living in high-risk neighborhoods might select strategies of childrearing (i.e. protection and insulation from risk) that differ from those living in low-risk neighborhoods, constraining opportunities for social interaction and increasing isolation from peers and socialization activities. Environments in which ethnic and racial minority children live are characterized by residential

segregation (Logan et al. 2004), poor quality housing (Simmons 2001), limited resources, exposure to violence (Jaycox et al. 2002) and fewer institutional and community support systems (Hoberman 1992). There is evidence showing how neighborhood safety relates to risk for mental illness (Alegria et al. 2007) and how neighborhood socio-economic conditions correlate with suicide rates, violence, adolescent well-being, and behavioral and emotional problems in children and youth (Baker and Taylor 1997; Ferrada-Noli 1997; Furstenberg and Hughes 1997; Sampson et al. 1997). The work of Sampson et al. (1997) underscores how the ability of adults in the neighborhood to regulate social behavior, as evidenced by high levels of collective efficacy, is associated with neighborhood levels of violence and personal victimization. These data underscore the importance of the neighborhood environment to children's mental health. For clinicians serving diverse children and youth populations in marginalized and segregated communities, understanding neighborhood conditions and community supports may be paramount. A better understanding of the context of childrens' and families' lives may allow them to identify what precipitates a child's negative behaviors and increases their chances of developing mental illness.

In addition to living in neighborhoods with high levels of environmental stress, ethnic and racial minority youth are disproportionally more likely to have interactions with the juvenile justice system (Freudenberg and Ruglis 2007; Lauritsen 2005), or to have relatives involved in the criminal justice system as compared to their white peers. As a consequence, these minority youth may expect greater injustice from formal institutions (Woolard et al. 2008). Persistent exposure to discrimination and racial profiling (Rousseau et al. 2009) can also impact their ability to trust and collaborate with mental health providers. Community, religious, and social agencies are therefore more typically trusted as resources to confront the hardships and stressors associated with their own and/or their family's living circumstances (Alegria et al. 2002). Expectations of misunderstanding and/or coercion within traditional institutional services (e.g. schools, police, and government services) tend to discourage minority youth and families from seeking professional mental health care (Takeuchi et al. 1993). As a result, there is a larger gap between the mental health service system's offerings in contrast to the negative expectations and unmet needs of diverse children and youth.

Relying on a traditional clinical approach, the mental health system is often ill prepared to serve a diverse clientele. Differences in culture, language, family composition, living arrangements, and neighborhoods lead multicultural youth and their families to have different expectations of clinical services. Mental health systems must now meet the needs of children (Williams and Collins 2001) that are very distinct from those that the system was developed to serve. Unfortunately, traditional practice models appear unresponsive to the special needs and the most pressing concerns of multicultural youth and their families. This may leave them without care, or it may cause them to prematurely drop out of care.

A Failing Children-Adolescent Mental Health Service System

While children on average are often underserved by mental health care in the United States, ethnic and racial minority children receive an average of half as many counseling sessions (Pumariega et al. 1998) than their white counterparts. As compared to non-Latino whites, both Latino and African-American youth exhibit lower rates of mental health service use (Kataoka et al. 2002; Yeh et al. 2003), make fewer office visits for treating their attention deficit hyperactivity disorder (ADHD) and depression (Olfson et al. 2003a; b), and enter care later. Ethnic and racial minority youth are also less likely to receive multimodality treatments for their ADHD (Bussing et al. 1998) or formal services for their suicide attempts (Freedenthal 2007), in contrast to their white counterparts. Thus, the evidence suggests that the mental health system is failing many minority children and families as indicated by low rates of entry into care, high rates of drop out, and greater rates of unmet need for mental health services. As described above, one potential explanation for the system's failure might be the inattention paid to the culture, context and diversity of multicultural children and families.

The Role of Culture and Context: Why it Matters

Culture, in its simplest definition, is a set of shared understandings, a view of "how we do things around here" (Glisson and James 2002; Hofstede 1998) that is socially constructed and evolving. Those who write about culture refer to it as "contextual, emergent, improvisational, transformational, and political (Laird 1998)," so that a group's cultural identity can evolve over time or in reaction to the environment or retrench toward some core values, given certain stresses. As such, it exists at all levels in a society—individuals come from a "cultural milieu" that they carry with them. As they join together with others (in communities, schools, or organizations), a shared set of beliefs and understanding emerges. As this suggests, culture is always dynamic and emergent in social interactions. When cultural elements (i.e., beliefs, values, routines) align across levels (e.g. family, peers, neighborhood), it is almost invisible. In this scenario, cultural competence is rarely an issue. However, in our multi-cultural, complex society,

with a host of "cross-cutting parameters," culture is often visible—in different assumptions, ways of interacting, values, and goals. It is this complexity of people attempting to survive and thrive in multiple cultures that makes current concepts of "cultural competence" and "diversity" essential to the delivery of culturally relevant and effective mental health treatment (Bigby et al. 2004). For the clinician who has innate biases and assumptions about behavior and child development given the mainstream culture becoming "culturally competent" to an evolving and dynamic culture of diverse patients becomes a challenge, possibly a myth (Dean 2001). Acquiring awareness of these biases, developing cultural humility and reflection, and attempting to address these biases is a process that proceeds in stages, so that being culturally "naive" is not a fault but a starting place.

At its most basic level, "mental health" is a cultural construct—our society has, via cultural agents (i.e., psychiatrists, psychologists, DSM-IV, legal system), defined mental health and mental illness in a way that corresponds to our underlying Western-majority culture. Our society has a long-standing and uneasy cultural view of where the boundaries of mental illness should lie—e.g., the "bad vs. mad" distinction has long been debated. Hence, even the focus of mental health treatment, itself, is NOT self-evident—rather what's seen as "normal" is shaped by views, assumptions, and orientations that are, at their core, cultural judgments (Erikson 1966; Goffman 1963).

Therefore, it is not surprising that when a complex and diverse society, such as ours, faces these essential questions of acceptable vs. unacceptable behavior, treatment vs. punishment, then the underlying cultures of the different stakeholders may not be completely in sync with these definitions. It is also not surprising that as people become more involved in the mental health "system," they find the "sticking points" where their cultural beliefs do not completely map with prevailing paradigms and where, as diverse families interact, they develop new awareness and understandings. In short, they develop a culture that explicitly incorporates views of mental health, treatment, clinician roles, etc. However, as with any culture, this developed culture builds from what already exists (in participating individuals, families, communities, organizations) to become a newly created culture shared by the participants and enacted within the clinical encounter. Whether this emerging culture feels comfortable, hostile, hierarchical, etc. must be negotiated (often without explicit recognition of the process) by the involved stakeholders over time. For a new multicultural family coming to mental health care, rarely does this negotiation ensue, leading to misunderstanding and potential drop out (Singh et al. 1999).

Discussions about culture or diversity revolve around these essential dynamic and multi-faceted processes of developing norms, beliefs, routines, and expectations that are shared between the family/youth and the provider. We often take the "short-hand" approach by thinking in terms of easily observed or known differences among people—skin color, language, where they (or their families) came from, SES, etc. But this is simply a convenient way to make sense of the much broader range of factors that influence perspectives, roles, understandings, values, etc. (i.e., culture). In the following sections, we think beyond these "easy" identifiers to begin tackling the difficult and pervasive ways in which culture influences (and is influenced by) the diversity of youth and families in subtle ways. Comprehending their experiences, situations, and organizations allows for a more holistic understanding about how culture may be useful in improving quality and processes in the mental health system for both the youth and their families. At the same time, the family/youth is scanning for cues (both in behavior and interaction) to evaluate if the provider really understands what matters more to them. Therefore, understanding culture is an interactive process that requires being open to learning about others as an ongoing process in both the family/youth and the provider.

Although most mental health treatments in urban clinics tend to be cross-cultural, providers vary tremendously in the extent to which, and manner in which, they address ethnic/racial and cultural differences in the clinical encounter (Maxie et al. 2006). Cultural values also include expectations about age, gender, and family dynamics, as well as beliefs about health and health care (Geertz 1973); all potentially affecting decisions made during mental health care. A patient's ethnicity/race/culture may impact what s/he reports, what the clinician asks her/him to report, and how the clinician interprets the information provided (Burgess et al. 2004). "A cultural open perspective, therefore, can help clinicians and researchers become aware of their hidden assumptions, biases, stereotypes and limitations of current practice and can help them identify new approaches appropriate for treating the increasingly diverse populations seen in psychiatric services around the world"(Kirmayer and Minas 2000).

Thinking of Culture at the Individual Level

Culture, by definition, is *not* an individual construct but is developed interactively and is contextually defined. Individuals are embedded in a cultural milieu. Culture is formed from a dynamic combination of ascribed characteristics (e.g., race, sex, country of origin), achieved characteristics (e.g., education, gender, social position), and experiences (e.g., discrimination, hierarchies, success). Concepts of "cross-cutting parameters"(Blau 1974) and "correlated constraints" (Magnusson and Cairns 1996)

both seem relevant here. The former suggests that each individual is basically a Venn diagram of unique and overlapping components—recognizing each of these provides points for understanding individuality and for creating common linkages between/among diverse individuals. The latter suggests that each of these parameters does not operate separately—rather changes in one domain and has implications for expression/opportunities of other domains (Farmer and Farmer 2001; Farmer et al. 2007). There is also evidence that there are cultural determinants to our neurocognitive capacities to assess problems and formulate solutions (Hedden et al. 2008; Nisbett and Masuda 2003).

There can be several primary implications of this. Culture is complex and continuously emerging (dialectic of process is critical here). Adequate understanding of an individual's core beliefs, approaches to life, goals, etc. are likely to be more relevant than simple demographic categorizations. Yet, the most easily observed characteristics of an individual (e.g., race, sex, and age) may or may not be the most salient for understanding that person's culture in the clinical encounter.

Thinking of Culture at the Family Level

Families are central to the cross-generational conveyance of culture. Families also actively create their own culture (through both omission and commission). Understanding HOW a family works (expectations for behavior, values, norms, goals, etc.) IS an assessment of culture. Again, cross-cutting parameters are important here. How much a given individual within a family adheres to/subscribes to the dominant family culture is critical to understanding family dynamics. The "past is never past"—what used to be (either in this current family configuration or in members' families of origin) influences how current events are processed and integrated into the whole.

Assessing fit between family's culture and treatment culture is also essential (e.g., should problems be discussed? Should all family members have a say in decisions or should certain members make decisions and others follow? Is violence "normal"?). The child in therapy has a vast number of cultural and contextual influences on his or her ability to rebound and get better. The therapist who is sensitive to the culture of the child and family still cannot fully know the complexity of these influences on any given child. The therapists' ability to help a child get better is highly dependent upon many other factors and can be made better by his or her full engagement of the family. The 2,003 *Final Report of President's New Freedom Commission*, following an intensive investigation in the nation's mental health system, declared that treatment must be consumer and family driven. The National Federation conducted an intensive process to develop a working understanding of what it would mean to be family driven. That definition says that families *have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation* (National Federation of Families for Children's Mental Health 2008). The therapist who engages the family in decision making will be better able to provide therapy that appropriately responds to a child's culture and context.

The primary implications of this are that there's been a tremendous amount of effort/interest in family centered treatments. However, it seems fairly rare that providers actually seek a full understanding of a family's current "culture" by examining roles, expectations, goals, "fit," etc. The way a family experiences treatment, and wants to be involved in treatment are contingent upon the family's culture; yet this fundamental dynamic of the family is rarely assessed (López and Hernandez 1987). Recognizing the culture of the family and working to actively examine points of correspondence and difference from the culture of treatment is an essential part of quality treatment. Not all families need to participate in treatment in the same way and not all treatment needs to be conducted the same way across families.

Thinking of Culture at the Organizational Level

There has been a great deal of attention to the role of organizational culture in mental health treatment (e.g. Glisson's work and its off-shoots, particularly Glisson and Green 2006; Glisson and Hemmelgarn 1998; Glisson and James 2002; Glisson and Schoenwald 2005). This literature suggests the importance of recognizing the organizational culture for how treatment will be provided, whether evidence-based interventions are likely to be conducted, and their desired outcomes. Specifically, Glisson and Green (2006) have found that children attended by child welfare and juvenile justice case management units with constructive organizational cultures (those whose organizational norms and expectations promote that case managers be mutually supportive, expand their individual abilities, and preserve positive interpersonal relationships) were more likely to access needed mental health care. Glisson and James (2002) also demonstrated how constructive cultures in case management teams had a greater impact than climate on decreasing staff turnover, augmenting job satisfaction, and enhancing service quality.

Beyond these "usual" conceptualizations of organizational culture, it seems important to examine clinical policies, supervisory practices, referral practices, and linkages to the community as indicators of the organizational culture. To what extent does the way in which work is done in an organization reveal the organizational culture and

influence the recognition of culture at other levels? In addition, there seems to be more attention to organizational culture as an entity that is shaped by and affects employees than as a dynamic process that is relevant to and influenced by the interplay of these employees and families/youth they work with.

The work of Glisson and Hemmelgarn (1998) alludes to how youth's positive service outcomes greatly rely on the case manager's attention to each child's distinct needs, the caseworkers' responses to unanticipated problems brought by the family, and their persistence in traversing bureaucratic obstacles to attain needed services. But as Ware et al. (2000) so clearly describe, certain aspects of the organizational culture, like accountability, can increase the amount of paperwork required and consequently decrease clinical time to engage with the family/patient and negatively affect the ability to focus on the child's unique needs and respond to unexpected family challenges. So there is a strong interaction between how the organizational culture impacts the culture of providers and how, in response, this influences patient outcomes. An additional example is provided by Becker and Roblin's study (2008) showing a positive association between primary care practice climate and patients' trust in their primary care physicians, which also influenced greater patient activation. So practitioners and staff who described having more favorable practice climates (characterized by team orientation, task delegation, role collaboration, patient familiarity, and autonomy) had higher trust in their primary care practitioners, and these patients demonstrated higher patient activation.

But there are also ways in which the organizational culture negatively impacts patients. For example, it is very common in conversations and documentation in mental health facilities, to refer to "Mom" (i.e., "Mom has a new boyfriend," "Mom just started a new job," etc.). This somewhat innocuous language seems a serious violation of understanding both individual and family culture and recognizing families and individuals as unique ("Mom" as a proper noun is only appropriate in our culture to be used by a woman's offspring or others who view her as playing a "mothering" role in their lives). It is not used as a name for unrelated adult women (except in mental health settings). To do so suggests either (a) a familiarity that is inappropriate, or (b) a stereotype of the role that can be used as short-hand to describe the "typical" mother of a child with mental health problems. Either of these suggests an organizational culture that devalues families and individuals and resorts to simplistic categorizations to understand the needs, expectations and likely behavior of others.

The primary implications of this is that organizational culture is a "deep" or "meta" construct that characterizes an organization (Hofstede 1998; Rousseau 1990). Previous work suggests that it is important for explaining the way in which work is conducted, as well as the likelihood of innovation being accepted. More formal attention should be given to the ways in which organizational culture mirrors, supports, and diminishes the role of these diverse families' cultures at other levels. Changes in apparently "small" ways may create significant shifts in organizational culture and treatment (e.g., from the above example, requiring that children's mothers always be referred to by their name, rather than the generic "Mom"). Organizational culture appears to be more dynamic than it is often portrayed—recognizing the key individuals, relationships, factors that create "culture shifts" could be critical for understanding organizations, treatment, provider-patient relationships, and service outcomes.

Thinking About Culture at the Community/Society Level

Since the mid 1970s, many people have discussed the importance of "nesting," of an "ecological perspective." Bronfenbrenner's work (1997) is frequently cited but rarely taken seriously. All other levels of society are influenced by the broader community/society—whether as a base for the smaller unit's culture or in active contradiction/rebellion against it. For many individuals, families, and even organizations, the local community IS as "macro" as it gets. Adoption of expectations, norms, values, goals, traditions, from a relatively small physical region is typical for most people. Most people, including mental health providers, have a difficult time truly understanding cultures that are far from their own experiences. This does not refer to just "foreign" or "distant" cultures, but seems particularly relevant for understanding subcultures and individuals within the same overarching culture (e.g., truly grasping what it would be like to live in a culture very different from one's own experience. For example, where education is not valued for girls, where intra-family violence is "normal," where women work, where college attendance is expected, where evidence-based treatments are common, etc.). It's much easier to make general statements about cultural differences and to then superimpose this additional dimension on one's own cultural understanding, than it is to truly grapple with what it means (at all levels) to be of a different culture.

Like individuals, families, and organizations, culture is a dynamic process in communities. Given the natural inertia of large entities, culture is probably less changeable at this level. However, it is critical to recognize this process of sociopolitical change. It is also important to recognize "enacted culture" as well as espoused culture (e.g., for the "takes a village…" example, this is a popular statement of cultural values. However, when no one volunteers for mentoring, respite, etc., it suggests that the actual cultural

values may be substantially different than the voiced ones). Sub-cultures are a critical element of community/societal culture. As with other levels, the cross-cutting parameters that define these, both by isolating and connecting are critical.

The primary implications of this are that cultural and contextual sensitivity and awareness seem essential for recognizing diversity. However, these factors are unlikely to result in mental health professionals breaking completely free from their own culture and context to truly understand and experience the world of diverse children and families through a different cultural lens. Rather, they should be helpful for recognizing the mental health provider's own assumptions, expectations, norms, biases etc. and to open the door to exploring how these correspond to those of "others"—that is their patients and families. Examining enacted culture (i.e., actual behavior) in their diverse patients may be a better indicator of core beliefs, norms, etc. than getting reports of expressed culture. Societal culture is experienced by these families and youths through the filters of the "closer" levels (e.g., organizations, family). Therefore, as with the other levels, this makes it inappropriate to assume one's culture based on observable or knowable characteristics. Rather, cultural considerations must be one of the driving forces in improving services for diverse children and youth and cultural ways of healing should be honored, supported and funded. This might require a paradigmatic shift in how we approach and offer mental health care that seriously considers diversity, culture and context.

In order to achieve cultural awareness, understanding, and respect, we propose the following:

- the adoption of a public health model with integration of prevention and intervention efforts as the first line of "treatment"
- the development of community/family partnerships that can help realign the mental health services to the needs of these diverse children and families; and
- a change in organizational culture.

How Do We Accomplish this Paradigmatic Shift?

The foregoing analysis demonstrates that distinct worldviews, shaped by culture, exist at the level of the individual, family, neighborhood, and clinic. The worldview of the youth and family may not fit the cultural assumptions of Western mental health treatment. On the other hand, the worldview of the treating clinician may bias assessments toward "pathologizing" thoughts, emotions, and behaviors that are common to a particular culture. Because these cultural disparities inevitably lead to ineffective treatment, it is incumbent on clinicians and clinics to recognize the way in which their cultural insensitivities are expressed in clinical practices and organizational policies. A paradigm shift is needed through which clinicians and the institutions that support clinicians come to the fundamental recognition that understanding of one's culture is vitally important to treatment success and that each participant in the treatment process has a unique worldview that is shaped by each participant's personal culture. The remainder of this paper will focus upon various strategies to achieve this paradigm shift within the mental health system toward greater accommodation of culture as a fundamental aspect of mental health services.

A Public Health Model as a Way to Take Diversity, Culture and Context Seriously

Despite a long-standing call for a public health framework for children's mental health services (Bronfenbrenner 1997; Institute of Medicine 1994, 2009), there has been little progress towards this goal and no infrastructure to support universal prevention programs for mental health. Instead, prevention programs are most commonly tangential to the goals of the contexts in which they are implemented, such as social emotional programming in schools, or mental health diagnosis and treatment in primary care, with uneven effects and poor sustainability. As an alternative to the current system of mental health services, we suggest that a public health framework would promote children's adaptive functioning within key ecological contexts, enhancing sustainable setting-specific goals and processes in the communities where these diverse youth live.

The major implication of integrating mental health goals into the ongoing tasks of key natural settings is to acknowledge the diversity related to the range of persons and contexts important to children's development. Acknowledging the importance of key ecological contexts to children's development would encourage an alignment of mental health research, programs, and resources to the key predictors that promote successful adaptation *in that setting*, including an appreciation for cultural norms and values endemic to each setting. To that end, change emanates from within the context and it is the *form or structure* of contexts that would guide services (Frazier et al. 2007). A second implication of aligning mental health services to accommodate natural contexts is the identification and support of indigenous resources within these contexts who can serve as agents of change. This follows logically from the prioritizing of setting goals and is important both to ensure the sustainability of program goals and processes as well as to integrate the norms and values of key members of the setting.

Development of Community/Family Partnerships to Realign Mental Health Services

Community-based interventions have shown promise across a range of illnesses and populations (Borg 2002; Schooler et al. 1997; Sorensen 1998; Wagner et al. 2000), since conventional research and dissemination approaches to mental health care delivery have not resolved mental health problems among ethnic and racial minorities. This may be partly because these approaches may not respond effectively to the needs and life circumstances of these populations. Many of the risk factors (or antecedents) of disruptive and behavioral problems are associated with disadvantage and misfortune (Frick and Kimonis 2005). Living in a socially and economically depressed community plagued by joblessness and crime, being part of a home which lacks adequate resources, and having friends who practice risky behaviors like engaging in gang activity, are all risk factors for subsequent mental health problems that are embedded in the community. In order to overcome such risk factors, it is suggested that young people gain exposure to individuals and groups who espouse protective values and upon whose behavior they can model their own. A first step is to develop community/family partnerships that investigate with community members which types of family and youth supports would prevent community patterns leading to disruptive or problem behaviors of children in those communities as well as distinguish individuals and groups who promote protective values. Social and institutional supports occur best in the context of social supports, relationships and inclusion within the community. Participation and partnership with community agencies may be a vital way to generate youth inclusion and alternative supports that can facilitate preventive mental health and substance abuse treatment in settings outside specialty clinics.

This community-family partnership also requires increasing parents' political involvement in the design and implementation of collaborative mental health system enhancements that focus on the community system, and not on one particular child. Part of the effort would be to identify ways to maximize the mental health promoting capabilities of communities. The emphasis is on obtaining a deeper understanding of multiple factors and system patterns leading to disruptive or problem behaviors in children within their particular community context. Using this information, community agencies in alliance with mental health providers and families can establish empirically based strategies that are community centered and strength-based to reduce these disruptive youth behaviors.

Changing Organizational Culture in Mental Health Systems of Care

It is our nature as humans that we do not become aware of a constant until we experience a difference. For people who are raised in a racially homogeneous culture, there may be little awareness of the profound impact that culture has on a person's worldview. In order for a provider organization to become fully respectful and responsive to clients of other cultures in a broad sense, administrative and clinical managers must understand the cultural values inherent in a clinic's intake, assessment, and treatment methods. Once they are cognizant of these values, clinic managers should make every effort to alter practices to be more culturally responsive to diverse value sets. Where practices cannot be easily adapted for other cultures, providers should at least appreciate the challenges of "fit" between the families' culturally based worldview and that of the treatment milieu. To the extent possible, families and youth should be asked about their preferences. If the client's preferred treatment approach is not available, the treating clinician should solicit feedback from a cultural liaison (Kirmayer et al. 2003) throughout the course of treatment regarding how the recommended treatments can be adapted to the client's cultural preferences.

Provider organizations, such as community mental health centers, need to actively plan to become more responsive to their client's culture. All employees and associates of a provider organization must have an awareness of the impact of culture on treatment outcomes. This awareness of culture should be reflected in all provider policies and practices related to client engagement and inclusion, needs assessment, case formulation, goal context, treatment intervention, and treatment location. Provider managers should understand that improved cultural awareness does not happen with a simple message to staff that it should happen. This message must be accompanied by structural changes (policies, client engagement strategies, linkages to culturally based community resources, a diversity advisory committee), as well as operational changes (clinical interventions that are sensitive to other worldviews and patterns of communication among family members). Such structural and operational changes are best accomplished when internal staff and external advisor-stakeholders cooperate to develop explicit work plans that are reviewed by management, and are celebrated by both the organization and the community.

We propose a set of suggestions for how the collective community of interested individuals wanting to reform children's mental health services might respond to the proposed paradigmatic shift.

Recommendations for Research

We will need to identify what it would take to build a new science base of community interventions research that takes into account the *culture* (refers to the broad, historically based sets of traditions, mores, folklore, interactional patterns, and values of the ethnocultural group) and *local context* (refers to the immediate expression of culture in community institutions and community life more generally), so that community mental health interventions are suited to the real-life circumstances facing diverse youth and their families. As a result, a new science of community intervention research within a public health model needs to be developed and tested. This type of community intervention would focus on how to enhance community impact and resource development, and how to measure community impact over and above the diverse youth's outcomes. This research would, as part of a public health model, consider a youth's resilience as stemming from maintaining a cultural anchor, mirroring not only innate qualities of the child and his/her culture, but also the capacity of the child's environments to provide access to mental health enhancing resources. The implications of this research approach are that we might start attending to cultural context as the focus of community mental health interventions, emphasizing interventions that address local community structures, norms, and resources to enhance community life of diverse youth and families, rather than addressing the individual difficulties of the youth. We would need to test whether these types of interventions close the gap between knowledge development and knowledge use in the community for improving the mental health of these diverse youth.

To assist in the implementation, we will need to explore models of multi-level community interventions that can be developed in partnership with families and practitioners, so as to integrate local cultural context in the conceptualization, implementation and outcome assessment of these interventions. Rather than beginning with specific community interventions, even if evidence-based, we may also need to delve into the value of tailoring community interventions on the basis of what families want and direct them on the development of local resources as an overarching intervention goal. We need to be able to answer what kinds of cultural considerations need to be adhered to in order to assess the relevance of community based interventions across cultures and local contexts. We would also need to test the *effects of participation and partnerships* on public health interventions and mental health outcomes to evaluate their contribution.

Recommendations for Providers

Child-adolescent service providers need to improve their own awareness of the importance of cultural differences as a factor that affects treatment outcomes. This will entail making providers mindful that as members of a dominant and different culture they can inadvertently be part of the power dynamics that shape the reality of smaller communities. It is therefore very important for providers to be cognizant of how different communities are, and not take their views and values for granted. Providers may also need to become conscious of their complicity in reproducing power dynamics within their professional culture. For example, social competence (Odom et al. 1992) judged to be inappropriate by a teacher, might be the only available behavioral option for certain youth in a setting that lacks personnel trained to conduct linguistically and culturally relevant instruction and remediation. Mental health providers may be unaware of the persistent inequities that characterize the educational experiences offered to non-Anglo students, and the paucity of ethnic training in teacher preparation programs (Figueroa et al. 1989). It is in this real world intersection that educators, researchers, parents and mental health providers must collaborate to develop service delivery models that help improve academic and mental health outcomes for these diverse children.

Similarly it is critical for providers to accurately and validly capture the views of diverse cultural groups when assessing mental health. This may require offering providers cultural liaisons (Kirmayer et al. 2003) or community aids (Katz and Shotter 1996) that can assist them in recognizing the significant role of culture, language, ethnicity, and local context in how diverse families prioritize, respond to and adhere to mental health treatments. A new approach to training providers would promote identifying social support and other contextual protective factors in the mental health of these diverse children that can be targeted by interventions. One potential venue might be expanding school-based mental health systems to enable community interventions that combine resources and perspectives from schools, parents, community liaisons, and mental health agencies to link underserved children to mental health services (U.S. Surgeon General 2001; Weist and Schlitt 1998).

To implement such advances might involve forming interagency coalitions and/or supporting learning collaboratives (Wenger et al. 2007) of parents, community leaders, teachers and school-based mental health workers that facilitate mutual learning and communication mechanisms among these groups. It might also entail conducting needs assessments to understand the linguistic, cultural, organizational, and regulatory barriers faced by these diverse families in achieving access to mental health enhancing resources in their communities. Also under consideration might be the establishment of clinical assistance teams and technological systems and processes (e.g., school-based

data management and web-based telecommunication) for information sharing and mental health consultation to community agencies. Furthermore, it might include developing tools that facilitate linking diverse families to community and state resources as well as linking providers to trainings for intervention development and consultation regarding mental health service delivery for these families.

Recommendations for Policymakers

Provider organizations cannot become more culturally responsive without supplemental resources and technical assistance at the federal, state, and local levels. It is difficult for provider organizations to become more culturally responsive without guidance and technical support from governmental agencies and private resources that have experience in the process of organizational change. Achieving a greater cultural awareness for the provider and the organization requires explicit planning and resources, as well as staff training and increased supervision. These indirect costs are not typically included in fee schedules for service payment and could be restructured as part of the payment structure. Federal, state, and private insurance payers must incorporate these indirect costs into their fee schedules; or find other mechanisms to pay for the expense of change, such as technical assistance centers that offer training and support without cost to the provider organization, and without passing these additional "costs" to already overburdened providers. To implement such a recommendation necessitates convening a working group of school personnel, investigators, policy makers and legislators for exploring funding and reimbursement mechanisms for some of the needed organizational and provider changes.

Recommendations for Consumers

Activating and training youth and caregivers on the importance of sharing with providers not only their mental health problems, but also information linked to their core beliefs, approaches to life, goals and expectation of treatments is vital. Emphasizing to youth and caregivers the importance of helping providers understand the youth's daily activities, peer relationships and family dynamics is indispensable so that the clinician does not have to use their preconceived notions. This can help contextualize the differences in the family's circumstances so that the provider makes fewer mistaken assumptions. Currently, consumers are likely to face linguistic and cultural distance with their mental health providers due to a shortage of bilingual and bicultural staff (Malgady and Zayas 2001).As a result, biases may interfere with both the diagnostic and intervention processes leading to misinterpretation (Malgady and Zayas 2001) and poor treatment outcomes.

Also necessary may be the development of a mental health literacy training program for caregivers of diverse youth suffering from mental health problems that can improve recognition and overcome service use barriers. The purpose of this training would be to improve the capacity of community based agencies to engage with diverse families, particularly those unacculturated to the US and with limited language capacity regarding mental health awareness, management and treatment resources and options. To aid in the development of such literacy training may require collecting information from community agencies and mental health workers to inform the training and solicit community and expert input in the design and piloting of the literacy training program.

Conclusion

There is no question that major changes are required to develop and implement mental health services that better match diverse families' unique needs. We recognize that these changes require bold public health approaches and novel ways of bridging community/family partnerships to mental healthcare system constraints (Alegría et al. 2009). More importantly, however, they require the cultural and contextual tailoring necessary to bridge the quality chasm confronted by families with very diverse needs. Diversity, culture and context serve as the backdrop for the interpersonal dimension of mental health service delivery. As such, they inform the conceptualization of services that must meet the needs of a very diverse clientele and must be taken seriously by the mental health field. Service delivery is often intercultural; the dynamics of cross-cultural clinical and community work are critically important to understanding and refining our services and practices. We believe the proposed changes are necessary to address a fundamental problem which negatively impacts mental health service delivery for multicultural youth and adolescents, and to foster the development of natural supports that may provide a more efficient use of resources so that diverse children can thrive, especially those in high-risk communities and settings.

References

Alarcón, R. D. (2003). Mental health and mental health care in Latin America. *World Psychiatry, 2*(1), 54–56.

Alegría, M., Canino, G., & Pescosolido, B. (2009). A socio-cultural framework for mental health and substance abuse service disparities. In B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Comprehensive textbook of psychiatry*. Baltimore: Wolters Kluwer Health, Lippincott Williams & Wilkins.

Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., et al. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. *Psychiatric Services, 53*(12), 1547–1555.

Alegria, M., Sribney, W., Woo, M., Torres, M., & Guarnaccia, P. (2007). Looking beyond nativity: The relation of age of immigration, length of residence, and birth cohorts to the risk of onset of psychiatric disorders for Latinos. *Research in Human Development, 4*(1–2), 19–47.

Alem, A., Jacobsson, L., Araya, M., Kebede, D., & Kullgren, G. (1999). How are mental disorders seen and where is help sought in a rural Ethiopian community? A key informant study in Butajira, Ethiopia. *Acta Psychiatrica Scandinavica, 100*, 40–47.

Baker, D., & Taylor, H. (1997). Inequality in health and health service use for mothers of young children in Southwest England. *Journal of Epidemiology and Community Health, 51*, 74–79.

Becker, E. R., & Roblin, D. W. (2008). Translating primary care practice climate into patient activation: The role of patient trust in physician. *Medical Care, 46*(8), 795–805.

Belsky, J., Steinberg, L., & Draper, P. (1991). Childhood experience, interpersonal development, and reproductive strategy: An evolutionary theory of socialization. *Child Development, 62*(4), 647–670.

Bigby, J. A., & Perez-Stable, E. (2004). The challenge of understanding and eliminating racial and ethnic disparities in health. *Journal of General Internal Medicine, 19*(2), 201–203.

Blau, P. M. (1974). Presidential address: Parameters of social structure. *American Sociological Review, 39*(5), 615–635.

Borg, M. B. (2002). The Avalon gardens men's association: A community health psychology case study. *Journal of Health Psychology, 7*(3), 345–347.

Bronfenbrenner, K. (1997). The role of union strategies in NLRB certification elections. *Industrial and Labor Relations Review, 50*, 195–212.

Browman, C. L. (1996). The health consequences of racial discrimination: A study of African Americans. *Ethnicity and Disease, 6*, 148–153.

Burgess, D., Fu, S., & van Ryan, M. (2004). Why do providers contribute to disparities and what can be done about it? *Journal of General Internal Medicine, 19*, 1154–1159.

Burkard, A. W., Ponterotto, J. G., Reynolds, A. L., & Alfonso, V. C. (1999). White counselor trainees' racial identity and working alliance perceptions. *Journal of Counseling and Development, 77*(3), 324–329.

Bussing, R., Schoenberg, N., & Perwien, A. (1998). Knowledge and information about ADHD: Evidence of cultural differences among African-American and. *white parents, 46*(7), 919–928.

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., et al. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology, 70*(1), 44–55.

Cheng, D., Leong, F. T. L., & Geist, R. (1993). Cultural differences in psychological distress between Asian and Caucasian American college students. *Journal of Multicultural Counseling and Development, 21*(3), 182–190.

Cheung, F. K., & Snowden, L. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal, 26*(3), 277–291.

Cicchetti, D., & Rizley, R. (2006). Developmental perspectives on the etiology, intergenerational transmission, and sequelae of child maltreatment. *New Directions for Child and Adolescent Development, 1981*(11), 31–55.

Cinnirella, M., & Loewenthal, K. M. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology, 72*(4), 505–524.

Connect for Kids (2006). Children of immigrants: What does the future hold? Retrieved November 9, 2009, from http://www.connectforkids.org/node/4016.

Dean, R. (2001). The myth of cross-cultural competence. *Families in Society: The Journal of Contemporary Human Services, 82*(6), 623–630.

Desjarlais, R. R. (1995). *World mental health: Problems and priorities in low-income countries*. USA: Oxford University Press.

Draper, P., & Harpending, H. (1982). Father absence and reproductive strategy: An evolutionary perspective. *Journal of Anthropological Research, 38*(3), 255–273.

Dressler, W., & Badger, L. (1985). Epidemiology of depressive symptoms in black communities. A comparative analysis. *Journal of Nervous and Mental Disease, 173*(4), 212–220.

Erikson, K. T. (1966). *Wayward puritans: A study in the sociology of deviance*. New York: Wiley.

Farmer, T. W., & Farmer, E. M. Z. (2001). Developmental science, systems of care, and prevention of emotional and behavioral problems in youth. *American Journal of Orthopsychiatry, 71*(2), 171–181.

Farmer, T. W., Farmer, E. M. Z., Estell, D. B., & Hutchins, B. (2007). The developmental dynamics of aggression and the prevention of school violence. *Journal of Emotional and Behavioral Disorders, 15*(4), 197–208.

Ferrada-Noli, M. (1997). Health and socioeconomic indicators in Psychiatric Catchment Areas with divergent suicide rates. *Psychological Reports, 81*, 611–619.

Figueroa, R. A., Fradd, S. H., & Correa, V. I. (1989). Bilingual special education and this special issue. *Exceptional Children, 56*(2), 174–178.

Flores, G., & Tomany-Korman, S. C. (2008). Racial and ethnic disparities in medical and dental health, access to care, and use of services in US children. *Pediatrics, 121*(2), e286–e298.

Frazier, S. L., Cappella, E., & Atkins, M. S. (2007). Linking mental health and after school systems for children in urban poverty: Preventing problems, promoting possibilities. *Administration and Policy in Mental Health and Mental Health Services Research, 34*(4), 389–399.

Freedenthal, S. (2007). Racial disparities in mental health service use by adolescents who thought about or attempted suicide. *Suicide and Life-Threatening Behavior, 37*(1), 22–34.

Freudenberg, N., & Ruglis, J. (2007). Reframing school dropout as a public health issue. *Preventing chronic disease, 4*(4). http://www.cdc.gov/pcd/issues/2007/oct/2007_0063.htm.

Frick, P. J., & Kimonis, E. R. (2005). Externalizing disorders of childhood and adolescence. In J. E. Maddux & B. A. Winstead (Eds.), *Pscyhopathology: Foundations for a contemporary understanding Mahwah*. NJ: Lawrence Erlbaum Associates.

Furstenberg, F., & Hughes, M. E. (1997). The influence of neighborhoods on children's development: A theoretical perspective and a research agenda. In J. Brooks-Gunn, G. Duncan, & J. L. Aber (Eds.), *Neighborhood Poverty: Volume II: Policy implications in studying neighborhoods* (pp. 23–47). New York, NY: Russel Sage Foundation.

Geertz, C. (1973). *The interpretation of cultures*. New York: Basic Books.

Glisson, C., & Green, P. (2006). The effects of organizational culture and climate on the access to mental health care in child welfare and juvenile justice systems. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(4), 433–448.

Glisson, C., & Hemmelgarn, A. L. (1998). The effects of organizational climate and interorganizational coordination on the quality

of outcomes of children's service systems. *Child Abuse and Neglect, 22*(5), 401–421.

Glisson, C., & James, L. R. (2002). The cross-level effects of culture and climate in human service teams. *Journal of Organizational Behavior, 23*(6), 767–794.

Glisson, C., & Schoenwald, S. K. (2005). The ARC organizational and community intervention strategy for implementing evidence-based children's mental health treatments. *Mental Health Services Research, 7*(4), 243–259.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Gureje, O., & Alem, A. (2000). Mental health policy development in Africa. *Bulletin of the World Health Organization, 78*, 475–482.

Hedden, T., Ketay, S., Aron, A., Rose Markus, H., & Gabrieli, J. D. (2008). Cultural influences on neural substrates of attentional control. *Psychological Science, 19*(1), 12–17.

Hoberman, H. M. (1992). Ethnic minority status and adolescent mental health services utilization. *The Journal of Behavioral Health Services and Research, 19*(3), 246–267.

Hofstede, G. (1998). Attitudes, values and organizational culture: disentangling the concepts. *Organization Studies, 19*(3), 477–493.

Huang, F., Chung, H., Kroenke, K., Delucchi, K., & Spitzer, R. (2006). Using the Patient Health Questionnaire-9 to measure depression among racially and ethnically diverse primary care patients. *Journal of General Internal Medicine, 21*(6), 547–552.

Institute of Medicine. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.

Institute of Medicine. (2009). *Focusing on children's health: Community approaches to addressing health disparities. Workshop summary*. Washington, DC: National Academy Press.

Jaycox, L. H., Stein, B. D., Kataoka, S. H., Wong, M., Fink, A., Escudero, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(9), 1104–1110.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*(9), 1548–1555.

Katz, A. M., & Alegría, M. (2009). The clinical encounter as local moral world: Shifts of assumptions and transformation in relational context. *Social Science and Medicine, 68*(7), 1238–1246.

Katz, A., & Shotter, J. (1996). Hearing the patient's voice: Toward a 'social poetics' in diagnostic interviews. *Social Science and Medicine, 43*, 919–931.

Kirmayer, L., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *Canadian Journal of Psychiatry, 48*(3), 145.

Kirmayer, L. J., & Minas, H. (2000). The future of cultural psychiatry: An international perspective. *Canadian Journal of Psychiatry, 45*(5), 438–446.

Kleinman, A., Eisenberg, L., & Good, B. (2006). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Focus: The Journal of Lifelong Learning in Psychiatry, 4*(1), 140–149.

Kreider, R. M., & Fields, J. (2005). *Living arrangements of children: 2001*: US Census Bureau.

Laird, J. (1998). Theorizing Culture. In M. McGoldrick (Ed.), *Re-visioning family therapy* (pp. 20–36). New York: Guilford Press.

Lauritsen, J. L. (2005). Racial and ethnic differences in juvenile offending. In *Our children, their children: Confronting racial and ethnic differences in American juvenile justice* (pp. 83–104).

Logan, J. R., Stults, B. J., & Farley, R. (2004). Segregation of minorities in the metropolis: Two decades of change. *Demography, 41*(1), 1–22.

López, S., & Hernandez, P. (1987). When culture is considered in the evaluation and treatment of Hispanic patients. *Psychotherapy, 24*(1), 120–126.

Magnusson, D., & Cairns, R. B. (1996). Developmental science: Toward a unified framework. In R. B. Cairns, G. H. Elder, & E. J. Costello (Eds.), *Developmental science* (pp. 7–30). New York: Cambridge University Press.

Malgady, R. G., & Zayas, L. H. (2001). Cultural and linguistic considerations in psychodiagnosis with Hispanics: The need for an empirically informed process model. *Social Work, 46*(1), 39–49.

Maxie, A., Arnold, D., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy. *Psychotherapy: Theory, Research, Practice Training, 43*(1), 85–98.

National Federation of Families for Children's Mental Health. (2008). *Working definition of family-driven care.*

Nisbett, R. E., & Masuda, T. (2003). Culture and point of view. *Proceedings of the National Academy of Sciences, 100*(19), 11163–11170.

Novins, D. K., Bechtold, D. W., Sack, W. H., Thompson, J., Carter, D. R., & Manson, S. M. (1997). The DSM-IV outline for cultural formulation: A critical demonstration with American Indian children. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(9), 1244–1251.

Oades-Sese, G. V., & Esquivel, G. B. (2006). Resilience among at-risk Hispanic American preschool children. *Annals of the New York Academy of Sciences, 1094*(1), 335–339.

Odom, S. L., McConnell, S. R., & McEvoy, M. A. (1992). *Peer-related social competence and its significance for young children with disabilities*. Social competence of young children with disabilities: Issues and strategies for intervention, 3–36.

Olfson, M., Gameroff, M., Marcus, S., & Jensen, P. (2003a). National trends in the treatment of attention deficit hyperactivity disorder. *American Journal of Psychiatry, 160*(6), 1071–1077.

Olfson, M., Gameroff, M., Marcus, S., & Waslick, B. (2003b). Outpatient treatment of child and adolescent depression in the United States. *Archives of General Psychiatry, 60*(12), 1236–1242.

Pumariega, A., Glover, S., Holzer, C., & Nguyen, H. (1998). Administrative update: utilization of services. *II. Utilization of mental health services in a tri-ethnic sample of adolescents. Community Mental Health Journal, 34*(2), 145–156.

Razali, S. M., Khan, U. A., & Hasanah, C. I. (1996). Belief in supernatural causes of mental illness among Malay patients: impact on treatment. *Acta Psychiatrica Scandinavica, 94*(4), 229–233.

Rousseau, D. M. (1990). Normative beliefs in fund-raising organizations: Linking culture to organizational performance and individual responses. *Group and Organization Management, 15*(4), 448–460.

Rousseau, C., Hassan, G., Measham, T., Moreau, N., Lashley, M., Castro, T., et al. (2009). From the family universe to the outside world: Family relations, school attitude, and perception of racism in Caribbean and Filipino adolescents. *Health and Place, 15*(3), 751–760.

Saeed, K., Gater, R., Hussain, A., & Mubbashar, M. (2000). The prevalence, classification and treatment of mental disorders among attenders of native faith healers in rural Pakistan. *Social Psychiatry and Psychiatric Epidemiology, 35*(10), 480–485.

Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science, 277*, 918–924.

Schooler, C., Farquhar, J. W., Fortmann, S. P., & Flora, J. A. (1997). Synthesis of findings and issues from community prevention trials. *Annals of Epidemiology, S7*, S54–S68.

Simmons, P. A. (2001). *Changes in minority homeownership during the 1990s.* Fannie Mae Foundation Census Notes.

Singer, A. (2002). *America's diversity at the beginning of the 21st century: Reflections from census 2000*. The Brookings Institution.

Singh, N. N., McKay, J. D., & Singh, A. N. (1999). The need for cultural brokers in mental health services. *Journal of Child and Family Studies, 8*(1), 1–10.

Snowden, L. R., & Yamada, A. M. (2004). Cultural differences in access to care. *Annual Review of Clinical Psychology, 1*, 143–166.

Sorensen, G. (1998). The effects of a health promotion-health protection intervention on behavior change: The well works study. *American Journal of Public Health, 88*(11), 1685–1690.

Surgeon General, U. S. (2001). *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the surgeon general*. Washington, DC: U.S. Department of Health and Human Services.

Suurmond, J., & Seeleman, C. (2006). Shared decision-making in an intercultural context Barriers in the interaction between physicians and immigrant patients. *Patient Education and Counseling, 60*(2), 253–259.

Takeuchi, D., Bui, K., & Kim, L. (1993). The referral of minority adolescents to community mental health centers. *Journal of Health and Social Behavior, 34*, 153–164.

Vega, W. A., & Rumbaut, R. G. (1991). Ethnic minorities and mental health. *Annual Review of Sociology, 17*(1), 351–383.

Wagner, E. H., Wickizer, T. M., Cheadle, A., Psaty, B. M., Koepsell, T. D., Diehr, P., et al. (2000). The kaiser family foundation community health promotion grants program. *Health Services Research, 35*(3), 560–589.

Ware, N. C., Lachicotte, W. S., Kirschner, S. R., Cortes, D. E., & Good, B. J. (2000). Clinician experiences of managed mental health care: A rereading of the threat. *Medical Anthropology Quarterly, 14*(1), 3–27.

Weist, M. D., & Schlitt, J. (1998). Alliances and school-based health care. *Journal of School Health, 68*, 401–404.

Wenger, E., McDermott, R., & Snyder, W. (2007). *Cultivating communities of practice: A guide to managing knowledge*. Boston, MA: Harvard Business School Press.

Whyte, S. R. (1991). Attitudes towards mental health problems in Tanzania. *Acta Psychiatrica Scandinavica, 83*(S364), 59–76.

Williams, D., & Collins, C. (2001). Racial residential segregation: A fundamental cause of racial disparities in health. *Public Health Reports, 116*(5), 404–416.

Woolard, J. L., Cleary, H. M. D., Harvell, S. A. S., & Chen, R. (2008). Examining adolescents' and their parents' conceptual and practical knowledge of police interrogation: A family dyad approach. *Journal of Youth and Adolescence, 37*(6), 685–698.

Yeh, M., McCabe, K., Hough, R. L., Dupuis, D., & Hazen, A. (2003). Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research, 5*(2), 65–77.