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Asian-American Children Treated in the Mental Health System: A Comparison of Parallel and Mainstream Outpatient Service Centers

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Examined differences between ethnic-specific and mainstream outpatient mental health services for Asian-American children. The study found that Asian-American children who received services at ethnic-specific centers were less likely to drop out of services after the first session, utilized more services, and had higher functioning scores at discharge than did those who attended mainstream centers, even when variables including social class and functioning score at admission were controlled. Centers were also compared on population characteristics and therapist–client ethnicity match. The findings suggest that ethnic-specific mental health centers are effective in serving the Asian-American child community.

Mental disorders are suffered by at least 7.5 million persons under the age of 18, or at least 12% of the youth population in the United States (National Institutes of Health, 1991). Attention has been drawn to the need for child services, but effective care has yet to be implemented on an adequate basis. In 1969, the Joint Commission on Mental Health of Children reported that millions of minors are not given the necessary mental health services and that those who do in fact receive care are often given unsuitable services. Since the publication of this Joint Commission, acknowledgment of children's mental health problems has increased. However, research continues to show that emotionally disturbed children and youth are not receiving appropriate care (Knitzer, 1982).

Services for Ethnic Minority Children

The 21st century will mark a time when those who are now called ethnic minorities will make up a larger portion of the population in some states than do those now called the majority (Cross, Bazron, Dennis, & Isaacs, 1989). In addition, McAdoo (1982) indicated that ethnic minority populations are younger than the Caucasian population and that the birth rates of ethnic minority groups are growing more rapidly than those of Caucasians. These population trends will inevitably impact the mental health system by increasing the number of ethnic children; it is estimated that by the year 2000, 40% of the service delivery population will consist of ethnic minority children and/or adults (Cross et al., 1989).

Yet, the mental health system has not prepared itself adequately for these changes in demographics, and research in this area is greatly lacking. Some states do not keep records of the number of ethnic minority children who receive mental health services (Cross et al., 1989), impeding service delivery investigation for this population. Although the number of ethnic minorities who enter the public mental health system is increasing, problems of underutilization remain that cannot be adequately understood without comprehensive research (Cheung & Snowden, 1990). Information about the population of emotionally disturbed minority children and the services provided to them is limited, and in addition, culture is often not included as a factor in research.

Even in those communities where the importance of developing ethnic-appropriate services has been acknowledged, issues of effective service delivery remain. In 1977, Sue recommended three alternative strategies for approaching program delivery to minorities: (a) Train existing agency personnel to be culturally sensitive, (b) establish parallel services that provide ethnic-specific services which are independent from mainstream organizations but similar in structure and function, or (c) provide nonparallel service organizations that have no precedence in the conventional mental health system. The second recommendation involved the hiring of bilingual and bicultural personnel; having signs, bulletins, and notices available in the clients' languages; having diets or other amenities con-

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sistent with the background of clients; and trying to create treatment interventions that are culturally sensitive. Recently there has been particular discussion concerning the relative benefits of providing separate ethnic-specific services compared to increasing the accessibility of mainstream agencies to minorities (Cross et al., 1989). There is some evidence that ethnic-specific services engender greater utilization by the ethnic adult community (Flaskerud, 1986; Lorenzo & Adler, 1984). However, these results have not been fully investigated, nor have they been replicated for minority children.

Regardless of the format used to address the needs of ethnic children, various factors must be considered in delivering appropriate services to this population. Bush, Glenwick, and Stephens (1986) reported that previous therapy exposure, therapist type, family system, experience of the therapist, and referral source were the strongest predictors of outcome for children in a community mental health setting. In addition, language and culture have been identified as major obstacles to delivering effective counselling to minority populations (Fox, 1984). Providing ethnocentric mental health services may have a significant impact on service effectiveness to minority groups (Fox, 1984).

This investigation is the first study ever conducted that examines the effectiveness of the parallel approach (i.e., mental health centers especially designed to serve ethnic populations) in delivering mental health services to the child of color. Asian-Americans were chosen as the specific population for study. Recognizing that in most cases the treatment initially provided to children and their families comes in the form of outpatient services (Stroul & Friedman, 1986), this study focused on outpatient service delivery facilities.

It was assumed that the creation of Asian-specific parallel services would facilitate utilization of services by Asian Americans as well as provide more effective services to this population. Research has demonstrated that Asians underutilize mental health services and have high dropout rates in community mental health centers (Sue & McKinney, 1975). In addition to addressing differences in language and culture, culturally responsive interventions such as sensitivity to shame, family involvement, and inclusion of traditional or ethnic medicine may be beneficial in providing effective treatment (Fox, 1984). Thus, it was hypothesized that Asian-specific parallel service centers would address Asian-American mental health needs more effectively than do mainstream centers.

To evaluate the success of parallel services in promoting greater utilization and treatment effectiveness for the Asian-American child population, four key hypotheses regarding the delivery of services to Asian-American children were tested:

1. Client characteristics: It was hypothesized that the two types of centers would have similar client characteristics.
2. Program characteristics: Parallel centers were hypothesized to be more effective in matching therapist ethnicity to client ethnicity.
3. Utilization: It was hypothesized that Asian-American children who utilize parallel services would be more likely to continue treatment than those in mainstream centers.
4. Outcome: It was hypothesized that Asian-American children in parallel services would have better treatment outcomes than those in mainstream centers.

Method

Subjects

This study consisted of Asian-American children 18 years of age or younger who used outpatient services at a Los Angeles County mental health facility between January 1, 1983 and December 31, 1988. Children who used emergency services or were assessment cases were excluded from the data set, and only first-time clients were included in the analyses, resulting in 912 total subjects.

Definition of Centers

Parallel. Centers were designated *parallel* if they were established to specifically provide mental health services to the Asian community. Such programs were established due to the knowledge that the ethnic minority population was growing and in need of specialized mental health services. Five such centers existed in Los Angeles County. However, one center was excluded from the analyses because it was established relatively recently during the five-year period of the study. From the four centers, a total of 489 parallel-center clients were used for analysis. (For specific information on the parallel centers, see the Appendix.)

Mainstream. Centers were designated *mainstream* if they did not identify themselves as specifically serving an ethnic-specific community, if they were not a juvenile detention facility, and if they had Caucasians as their largest client group. Juvenile detention facilities were excluded to conform to the nature of outpatient services offered by the parallel centers. Centers that served Caucasians as their largest client group were selected to compare centers that might be classified as serving the mainstream population, as some centers serve primarily African-American or Hispanic-American populations. Thirty-two centers were identified using this criteria, with a total of 423 clients.

Measures

Client characteristics. Client characteristics were examined on four variables: age, sex, Medi-Cal eligibility (socioeconomic status), and admission functioning level. Age was a continuous variable ranging from zero to 18 years. The client's Medi-Cal eligibility was determined by gross family income adjusted for the number of dependents in the child's household. Medi-Cal eligibility entitled the client to payment by the State of California for the use of health and mental health services. Thus, Medi-Cal status was used as a socioeconomic measure, with clients qualifying for Medi-Cal considered as being in poverty and children who did not qualify for Medi-Cal considered as not being in poverty. Admission functioning level consisted of a continuous Global Assessment Scale (GAS) score (Endicott, Spitzer, Fleiss, & Cohen, 1976). The GAS score measured the client's overall functioning and was based on psychological, social, and occupational dimensions, ranging from *the hypothetically sickest individual* (1) to *the hypothetically healthiest individual* (100). The admissions GAS score was determined by the admitting therapist.

Program characteristics. Programs were compared on the variable of ethnic match, which measured the number of times the center matched the therapist's specific ethnicity to that of the client (e.g., Chinese, Japanese, Korean, Filipino, or Vietnamese/Indochinese). This was identical to the ethnic match measure used in a previous study by Sue, Fujino, Hu, Takeuchi, and Zane (1991).

Utilization. Utilization of services was measured by two variables: dropout and length of treatment. Dropout, or premature termination, was the percentage of clients who did not return to the mental health facility following the first session. Using this dropout measure allowed comparison with other studies which have used the same criterion (Sue, 1977; Sue et al., 1991). Length of treatment was determined by the total number of sessions used by the clients.

Outcome. Outcome was measured by the functioning level at discharge, determined by the GAS score given to the client at termination of services.

Analyses

In the first set of analyses, parallel centers and mainstream centers were compared on client characteristics, program characteristics, utilization, and outcome variables. *T*-tests were conducted for continuous dependent variables, and chi-square tests were used for discrete dependent variables.

In the second set of analyses, regression analyses that controlled for covariates were conducted. In this way, these analyses controlled for several important confounding variables. First, population demographic differences between the parallel centers and mainstream centers may have influenced utilization and outcome findings. Second, it was important to discern whether parallel and mainstream center utilization and outcome differences were influenced by the higher proportion of ethnic match between client and therapist presumably offered by the parallel centers. Third, Asian Americans constitute many diverse ethnic groups, including Chinese, Japanese, Korean, Pacific Islanders, Filipinos, and Southeast Asians, that differ greatly in their U.S. immigration patterns, social status, economic status, and cultural values. Although analysis of each ethnic group would have been desirable, dividing each specific ethnic group into separate samples would not have provided adequate sample sizes for meaningful comparison. A decision was made to include an ethnicity variable in which the various Asian groups were compared to Southeast Asians. The Southeast Asians were selected as the baseline group because they were the largest group of Asian-Americans served in the dataset, and they were the group with the highest degree of presumed stress and pathology as a result of the trauma suffered through the Vietnam War and recent events occurring in Cambodia. Thus, the model controlled for Medi-Cal eligibility, functioning score at admission, age, ethnicity (Southeast Asian or not), sex, and ethnic match between client and therapist. A logistic regression was performed on the dichotomous dropout measure, and multiple regressions were conducted for the two continuous variables—length of treatment and functioning at discharge scores. Log transformations were performed on the actual number of sessions because a few clients attended a large number of sessions, creating a positively skewed distribution. The mode for total number of sessions for parallel centers was 4 (M = 16.53) with a range of 1 to 334, and the mode for mainstream centers was one session (M = 12.75) with a range of zero to 287. About 25% of the sample was missing GAS admission and/or termination scores and was deleted from the regression analyses. The distributions of the missing variables were comparable in both types of centers.

Results

Descriptive Analyses

Client Characteristics

As shown in Table 1, the results indicate some differences between clients in parallel services and those in mainstream centers. The samples did not differ in the

Table 1. *Comparison of Mainstream Centers and Parallel Centers on Client Characteristics, Program Characteristics, Utilization, and Outcome Variables*

Variable	Mainstream	Parallel
Client Characteristics		
Sample Size	423	489
Percentage Male	49	56*
Percentage Eligible for Medi-Cal	64	69
Age in Years		
M	12.76	11.94**
SD	4.24	4.25
GAS Admission		
M	45	52****
SD	15	10
Program Characteristics		
Percentage Ethnic Match	7.7	70.8***
Utilization		
Percentage Dropout	27.9	5.5***
Sessions[a]	1.57	2.20****
Outcome		
Mean GAS Discharge	49	56****

[a]Log transformed.
*$p < .05$. **$p < .01$. ***$p < .001$. ****$p < .0001$.

proportion of clients eligible for Medi-Cal. However, parallel centers served a greater proportion of male clients ($\chi^2 = 3.99, p < .05$), and the mean age of children served at mainstream centers was significantly higher than that of children served at parallel centers ($t = 2.91$, $p < .01$). The admission functioning scores of clients at parallel centers were also significantly higher than those of persons attending mainstream centers ($t = 6.61$, $p < .0001$).

Program Characteristics

As expected, analyses indicated that parallel centers differed significantly from mainstream centers in their ability to match the ethnicity of the therapist to the client. Parallel centers were able to match 71% of their Asian-American clients with therapists of the same ethnic background, whereas mainstream centers matched only 8% of their Asian-American clients ($\chi^2 = 367.09, p < .001$).

Utilization. Asian clients showed better service utilization patterns at parallel centers when compared to mainstream centers. Parallel centers had a 6% rate of client dropout after one session as compared to a 28% dropout rate after one session for mainstream centers ($\chi^2 = 84.67$, $p < .001$). Asian-American children also used a significantly greater number of sessions at parallel centers than at mainstream centers ($t = 7.72, p < .0001$).

Outcome. Client functioning scores at discharge were significantly higher for clients at parallel centers than at mainstream centers ($t = 6.20, p < .0001$).

Multivariate Analyses

As described earlier, it is possible that the higher utilization and outcome scores were due to factors other than type of service. There are three possible confounding sets of variables: First, the higher admission functioning scores of parallel-center clients may have led to greater utilization of services and a higher discharge functioning score. Second, demographic differences of age may also have contributed to utilization and outcome patterns. Finally, the fact that clients in parallel centers were more likely to be ethnically matched with their therapists may have led to increased utilization and outcome scores.

Therefore, a model was tested that controlled for possible confounding variables. Independent variables were Medi-Cal eligibility, functioning score at admission, age, ethnicity (Southeast Asian or not), sex, and ethnic match between client and therapist. A logistic regression was performed for the dropout measure, and multiple regressions were conducted for length of treatment and functioning at discharge scores.

Utilization. As shown in Table 2, the results indicate that even after controlling for client characteristics and ethnic match, clients at parallel centers continued to have a significantly lower likelihood of dropping out after the first session than did clients at mainstream centers. In fact, the odds ratio indicated that clients from mainstream services were over five times more likely to terminate after one session. An odds ratio greater than 1 indicates that a variable increases rate of dropout after the first session, and a ratio of less than 1 decreases the odds of dropping out after the first session. The odds ratio indicates that clients from parallel centers were likely to drop out 0.18 times to every 1 time a client dropped out of mainstream services. Thus, parallel-center clients were over five times less likely to terminate after one session. This odds ratio was computed from the log-

Table 2. *Odds Ratio for Demographic Variables and Covariates Predicting Dropout After One Session*

Variable	Odds Ratio
Center Type[a]	0.18****
Medi-Cal Eligibility[b]	2.86***
GAS Admission	0.97***
Age	1.07*
Ethnicity[c]	1.01
Sex[d]	0.78
Ethnic Match[e]	0.61

[a]Parallel center = 1. [b]Eligibility = 1. [c]Southeast Asian = 1. [d]Female = 1. [e]Match = 1.
*$p < .05$. **$p < .01$. ***$p < .001$. ****$p < .0001$.

odds unit logistic-regression coefficients. Antilogging the coefficient yielded the odds ratio figures.

Dropout rate was also significantly higher for those who were Medi-Cal eligible, had lower GAS scores at admission, and were older, when all other variables were held constant. (On the dichotomous variables in all of tables, variables were assigned a value of either zero or 1.)

Table 3 shows that clients in parallel centers received more treatment sessions in comparison to those in mainstream centers. Center type was the strongest predictor among all of those analyzed. Other variables significantly and independently related to a higher number of sessions were being younger, not being Southeast Asian, and not being Medi-Cal eligible.

Outcome. Based on multiple-regression analysis, parallel centers were found to be a significant predictor of higher functioning score for clients at discharge when compared to mainstream centers, as shown in Table 4. Thus, Asian children using parallel services had more favorable treatment outcomes than those using mainstream services. Not surprisingly, the client's functioning score at admission was the strongest predictor of outcome, and the strong relationship between admission and discharge functioning scores contributed to the larger R^2 value for the model in discharge functioning score ($R^2 = 0.57$) as compared to length of treatment ($R^2 = 0.14$). Client's ethnicity was also a significant predictor of discharge GAS score in that Southeast Asians were less likely to benefit from treatment than were the other Asians (e.g., Chinese, Japanese, Koreans, etc.).

Table 3. *Estimated Effect for Demographic Variables and Covariates Predicting Length of Treatment*

Variable	Standardized Beta Weight
Center Type[a]	0.30****
Medi-Cal Eligibility[b]	−0.16****
GAS Admission	0.01
Age	−0.13***
Ethnicity[c]	−0.10*
Sex[d]	0.03
Ethnic Match[e]	0.01
R^2 Value	.14

[a]Parallel center = 1. [b]Eligibility = 1. [c]Southeast Asian = 1. [d]Female = 1. [e]Match = 1.
*$p < .05$. **$p < .01$. ***$p < .001$. ****$p < .0001$.

Table 4. *Estimated Effect for Demographic Variables and Covariates Predicting Functioning Score at Discharge*

Variable	Standardized Beta Weight
Center Type[a]	0.12***
Medi-Cal Eligibility[b]	−0.04
GAS Admission	0.72****
Age	−0.05
Ethnicity[c]	−0.11****
Sex[d]	0.04
Ethnic Match[e]	−0.02
R^2 Value	.57

[a]Parallel center = 1. [b]Eligibility = 1. [c]Southeast Asian = 1. [d]Female = 1. [e]Match = 1.
*$p < .05$. **$p < .01$. ***$p < .001$. ****$p < .0001$.

Discussion

This study addressed four general areas in the comparison of parallel mental health centers with mainstream mental health centers: client characteristics, program characteristics in ethnic match, service utilization, and outcome of service. Implications for the service-delivery effectiveness of parallel centers are discussed in the context of these four areas.

Client Characteristics

One of the questions of this study was to explore whether parallel and mainstream centers served similar child populations. Contrary to hypothesis of no differences, the findings suggest that children entering parallel centers were less disturbed than those using mainstream services.

What are some possible reasons for the higher admission functioning scores for Asian Americans in parallel centers? An Asian family with a mildly disturbed child may be receptive to seeking services from a parallel center but may not have otherwise sought services from a mainstream center. In contrast, families with severely disturbed children who are more obviously in need of services may seek services in any case and do so from any source of treatment available to them. For example, a family with a mildly depressed child may be concerned for the child but may be deterred from seeking services from a mainstream center because of language and cultural barriers. However, they may be more apt to seek services from a parallel center where the office personnel and therapists speak the family's language and where cultural understanding is more readily available. Sue and McKinney (1975) argued that because of feelings of shame and the lack of culturally responsive services, only the most severely disturbed Asians may seek services. It seems plausible that services specially created to address the needs of Asian Americans may attract even the less severely disturbed. Furthermore, outreach programs implemented by parallel centers into the schools may broaden service delivery to include the less severely disturbed Asian-American pop-

ulation in addition to the severely disturbed population.

Parallel centers were found to serve younger clients than did mainstream centers. It is unclear why this is so, and further investigations are needed. The proportion of poor clients served did not differ across center type. Thus, there is no evidence of social class differences in the type of clients seeking services from mainstream or parallel centers.

Ethnic match. Parallel centers were able to match client and therapist ethnicity significantly more often than were mainstream centers. This match of ethnicity was expected by the very nature of parallel centers. Unlike a previous study of adults in which ethnic match was associated with length of treatment (Sue et al., 1991), the present results do not show that ethnic match is related to length of treatment. Perhaps ethnic match is more important for adults than children. Then, too, unlike adult clients, children have little choice in whether to continue or terminate treatment. These decisions are usually made by their parents.

Utilization. Asian clients showed better utilization patterns in terms of reduced client dropout and increased length of treatment at parallel centers than at mainstream centers, even when demographic variables, functioning at admission, and ethnic match of therapist to client were controlled. Parents may feel more comfortable in taking their children to an ethnic-specific service. This may especially be true for immigrants who have limited English proficiency and need to interact with Asian clerical and professional staff. Furthermore, the location of the parallel centers in close proximity to the targeted Asian communities may make access to services more convenient. Word-of-mouth communication, by which many client families within the Asian community come to hear about services, may promote a more positive feeling about the potential helpfulness of services and may lessen the shame associated with service utilization.

Outcome. Client functioning scores at discharge were higher for parallel center clients than for mainstream clients. We are not in a position to explain why Asian clients in parallel centers have better outcomes than those in mainstream centers. The better outcomes may be due to the presence of bilingual personnel, culturally responsive forms of treatment, a culturally familiar setting, and so on. What we do know is that the results strongly point to the beneficial effects of parallel centers.

Seven limitations of the study should be kept in mind. First, there was only one indicator of functioning—namely, the GAS. The reliability and validity of the GAS for Asian Americans have not been established. However, it is important to note that parallel services were associated not only with better GAS scores but also with more behavioral indicators such as decreased dropout rates and more treatment sessions. Second, the center type variable is a complex one, and, as mentioned previously, it is not possible to find what features or elements are responsible for the results. The purpose of this study was to establish parallel-center efficacy, and future research may elaborate further upon differences between mainstream and parallel centers. Third, although the subgroups of Asian Americans were not the primary focus of this study, it is important to note that when other Asian groups were compared to Southeast Asians, these groups achieved better outcomes and attended more sessions. This points to the need for research that examines ethnic differences within the Asian population. Furthermore, investigating the role of acculturation may be implicated, as Southeast Asians as a whole may be less acculturated than other Asian-American groups. Fourth, the children were not randomly assigned to centers, so that despite the efforts to control for client characteristics, we are not in a position to know if the clients using parallel versus mainstream centers are comparable. Fifth, the findings must be interpreted within the context of traditional mental health services, namely, outpatient, office-based therapies. Sixth, the study was not able to control for GAS score-rater ethnicity. It is possible that ratings given by a therapist of the same ethnicity as the client may differ from those given by therapists of a different ethnic group. Seventh, family and school response measures to therapy would have been beneficial but were unobtainable in the dataset. Nevertheless, this study is the first of its kind to investigate parallel services for any ethnic minority population, and the results are quite encouraging with respect to the important role that such services provide. The primary findings—namely, the lower dropout rates, greater number of sessions, and higher GAS outcome scores of Asian children using parallel rather than mainstream services—were of sufficient magnitude to indicate clinical as well as statistical significance. Future research should address more precisely the kinds of clients likely to use these services and the characteristics or processes that enhance treatment outcomes.

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Appendix: Asian-American Mental Health Centers

The four parallel centers included in this study were interviewed in order to provide a contextual background for understanding the service delivery statistics. The centers were the Asian Pacific Counseling and Treatment Center (APCTC), the Asian Pacific Family Center (APFC), the Coastal Asian Pacific Mental Health Services Center (CAPMHSC), and the Indochinese Counseling and Treatment Clinic (ICTC). This appendix provides a brief description of ethnic-specific service delivery for Asian-American children in Los Angeles. Information pertained primarily to the period of 1983 to 1988, during which the data for this study were examined.

APCTC

The APCTC was established in 1977 under the Los Angeles County Mental Health Department but was privatized in 1990 as a special service to groups with county contracts. The first designated child staff member came in 1985. In 1987, the staff expanded from 6¼ full-time equivalence (FTE) positions to 9¼ FTE positions plus part-time interns, with combined language capabilities in Vietnamese, Chinese (Mandarin and Cantonese), Korean, Tagalog, and Japanese. The APCTC is located in downtown Los Angeles and is intended to serve the inner city population. The spread-out nature of the Asian groups in downtown makes it difficult to locate the center closer to one or another group. In 1987, under AB 3632, the APCTC began an onsite school program.

APFC

The APFC was established in February 1986 as a private, nonprofit organization with county contracts under Pacific Clinics. During the period of 1986 to 1988, there were 17 total staff members with ethnic and language availabilities in Japanese, Korean, Vietnamese, and Chinese (including Taiwanese, Cantonese, Mandarin, and some other Chinese dialects). Most staff worked with both children and adults, and there were no separate services for children. The APFC is located in the center of the San Gabriel Valley near bus lines and a major freeway, providing convenient access to the targeted Asian population.

In 1987, the APFC began an onsite school-based program with one to two schools for the purpose of reaching the target population more effectively. Social workers and psychologists were sent to local school districts, some of which have over 60% Asian student populations. The staff would spend 2 to 3 hr a day, one day a week at the schools. Presently, the APFC provides group and individual services to four school districts, involving a total of nine schools.

CAPMHSC

The CAPMHSC began in 1984 as an outstation or extension of APCTC, but it became independent shortly after it was founded. Its goal was to reach the Los Angeles South Bay Asian population. Separate funding for children began in 1986. However, separation of program services for adults and children did not occur until 1990. In contrast to most mainstream Los Angeles County centers that had separate clinics for children and for adults, CAPMHS maintained separate budgets but had staff available to serve both children and adults in order to facilitate ethnic, language, and background match between client and therapist. In 1988, the staff consisted of eight members and included two and one-half staff members designated as child workers—all eight shared adult- and child-services responsibilities.

ICTC

The ICTC was founded in 1981 as a portion of the APCTC and does not have a separate children's services division. Prior to 1987, adult services handled both adult and child services. However, in late 1987 the Child and Youth Division of Los Angeles County assumed responsibility for the child services provided at the clinic. From 1983 to 1988, ICTC did not have its own child staff and borrowed staff members of the APCTC who used the ICTC location to serve clients.