

Building the Gateway to Success: An Appraisal of Progress in Reaching Underserved Families and Reducing Racial Disparities in School-Based Mental Health

Laurel Bear and Rosalie Finer
Alhambra Unified School District

Sisi Guo and Anna S. Lau
University of California, Los Angeles

School-based mental health (SBMH) services hold the promise of reducing barriers to care among underserved children and families in need, which can in turn reduce racial disparities in care. Yet, questions remain about the potential of SBMH for equitably reaching diverse communities. In particular, reaching Asian American youth in SBMH may remain a challenge even compared with other immigrant and ethnic minority groups, such as Latinos. This article describes the development and evaluates the service capacity of a SBMH platform in a medium-sized public school district serving predominantly low-income Latino and Asian American families. Service capacity was built through the creation and coordination of a system of community partnerships. Analyses of needs assessment and service referral and utilization patterns revealed no significant racial/ethnic differences in overall rates of mental health need between Latino and Asian American students; yet, Asian Americans were underrepresented in referrals to SBMH. However, once referred to care, there was no difference in the likelihood that Asian American and Latino students received treatment. Although there was an increase in capacity to link students to care, work remains to improve processes of identification to reduce unmet need across diverse groups.

Keywords: school-based mental health, racial disparities, referral, youth mental health need

School-based mental health (SBMH) services have been touted as an avenue for care delivery that can improve access to underserved youth and reduce racial disparities in mental health. Yet, there is as yet little evidence that SBMH reform results in parity of service delivery across racial/ethnic groups. The current study sought to critically examine whether the development of a robust SBMH platform leveling access to families in need could reduce or eliminate typically observed racial disparities in mental health care for youth. Thus, we examined the Gateway to Success program as a potential proof concept of the potential for SBMH reform to reduce inequities in care delivery in a public school district serving predominantly Latino and Asian American students. We described the implementation of the Gateway program and appraised its success in identifying need and delivering care equitably.

Racial Disparities in Mental Health Services for Youth

One in five youth experience mental health problems significant enough to impair their functioning (Duchnowski, Kutash, & Friedman, 2002; U.S. Department of Health & Human Services, 1999).

Yet youth mental health needs routinely go unrecognized, setting the course for poor outcomes through adulthood, such as low educational attainment and employment, physical health problems, and unnecessary suffering (Campbell & Ewing, 1990; Hofstra, van der Ende, & Verhulst, 2002; McGee, Feehan, Williams, & Anderson, 1992). Although the need for services is high, access and utilization of care is limited. Only 20% of youth with mental health need receive treatment (Kataoka, Zhang, & Wells, 2002). Rates of need among ethnic minority youth are no lower than among non-Hispanic Whites, but there are pronounced disparities in receipt of care, with ethnic minority children being less likely than non-Hispanic Whites to receive services even when controlling for symptom severity, impairment, insurance, and socioeconomic status (Garland et al., 2005). Barriers to care appear that disproportionately affect ethnic minority and immigrant youth include pragmatic barriers to access (e.g., insurance, transportation, language access, clinic hours), cultural barriers in problem recognition, beliefs about appropriate care, and stigma (Gudino, Lau, & Hough, 2008; Kodjo & Auinger, 2004; Slade, 2004; Yeh et al., 2003).

The Promise of School Based Mental Health (SBMH)

SBMH services have emerged to address these barriers to care (Adelman & Taylor, 2000; Flaherty, Weist, & Warner, 1996) and are integral to public education as untreated problem behaviors interfere with children's ability to benefit from instruction (Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999; Wang, Haertel, & Walberg, 1997; Zins, Weissberg, Wang, & Walberg, 2004). SBMH is much more likely to be utilized by children with mental health needs than specialty mental health care (Jaycox et al., 2010;

Laurel Bear and Rosalie Finer, Alhambra Unified School District; Sisi Guo and Anna S. Lau, Department of Psychology, University of California, Los Angeles.

Rosalie Finer is now in Private Practice, Encino, California.

Correspondence concerning this article should be addressed to Anna S. Lau, Department of Psychology, Box 951563, University of California, Los Angeles, CA 90095-1563. E-mail: alau@psych.ucla.edu

Kataoka et al., 2002). Situating care in schools reduces stigma and increases the likelihood of help-seeking (Slade, 2002). It is estimated that four of five youth in mental health treatment receive care in schools (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001).

SBMH has been touted as an innovative strategy that holds the promise of reducing unmet mental health need among youth, in general, and that can also reduce racial disparities in care (Lyon, Ludwig, Vander Stoep, Gudmundsen, & McCauley, 2013). Services provided in schools have extended the reach of care to youth and families from ethnic minority groups who are otherwise unlikely to access treatment (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). For example, in one study low-income Latino and African American youth were 20 times more likely to seek mental health services at a school based clinic than in community mental health centers over a 5-year period (Juszczak, Melinkovich & Kaplan, 2003). In a nationally representative sample, Cummings, Ponce, and Mays (2010) demonstrated clear racial disparities disfavoring African American, Asian American Pacific Islander, and Latino adolescents in treatment receipt for depression, suicidal ideation, and delinquency in specialty mental health settings. However, no such disparities were observed in SBMH where the odds of receiving treatment when evincing critical mental health needs are no lower for ethnic minority youth than for non-Hispanic White youth. As such, there may be some credence to the notion that SBMH represents an innovation in care delivery that reduces disparities in care by eliminating or reducing logistic barriers to access (e.g., clinic hours, transportation, insurance), decreasing stigma associated with mental health care, improving the chances of detecting mental health problems, and providing education and outreach (Keeton et al., 2012; Mandel & Qazilbash, 2005; Stephan et al., 2007).

Yet, although providing care in schools can increase access, inequities may still persist in SBMH. Even in SBMH, non-Hispanic White students are more likely than ethnic minority youth to receive care, to begin receiving care at an earlier age, and to be referred to specialty mental health clinics (Wood et al., 2005). A systematic review of school based health centers found that although such services are cited as being able to enhance access to care for medical, mental health, and substance abuse problems, a significant proportion of students remain underserved, particularly in mental health services (Mason-Jones et al., 2012). Despite students having access, delivery of care is limited (e.g., Adelman, Barker, & Nelson, 1993) and racial disparities in utilization may persist (Britto et al., 2001). Thus, it remains a question whether SBMH can routinely result in parity in the delivery of services using a variety of metrics from referral rates to ultimate linkage to care.

It is also important to note that discrepancies in service utilization are found not only between ethnicity minority youth and non-Hispanic White youth, but also between different ethnic minority groups (Gudino et al., 2008; Yeh et al., 2002). Asian Americans, in particular, may be more likely to have mental health needs go unmet in the school context even as compared to other immigrant and ethnic minority groups (Guo, Kataoka, Bear & Lau, 2014). Understanding rates of SBMH utilization in this population relative to other ethnic minority groups may be instructive, insofar as specific barriers facing particular groups may be distinct from factors that affect care for ethnic minority families, in general.

Common and Unique Barriers to Care Among Latino and Asian American Youth and Families

As two more recent immigrant groups, Latinos and Asian Americans face some similar barriers to mental health care. Both groups may be less likely to interface with mental health providers due to language and economic barriers (Snowden & Yamada, 2005). Compared with non-Hispanic Whites, Asian American and Latino families are more likely to be uninsured (Kataoka et al., 2002), and lacking in mental health literacy or awareness of children's mental health and information about available services (Abe-Kim et al., 2007). Finally, Asian American and Latino families likely share concerns about stigma associated with child treatment (Yeh et al., 2004). Asian American and Latino families also share an orientation toward family interdependence (Tseng, 2004), which may relate to a preference for resolving child behavior problems within the family without involving mental health professionals (Leong & Lau, 2001).

In contrast, salient differences between Asian American and Latino youth may contribute to different patterns of SBMH utilization. First, one of the most cited differences between the two groups concerns academic achievement and educational attainment. National reports reveal that Asian American students receive higher grades and achievement test scores, and are more likely to complete high school and enroll in postsecondary education than Latino youth (Pew Hispanic Center, 2009). Because academic problems play an important role in identification for services, school personnel may overlook emotional and behavioral problems among Asian American students with high or adequate academic performance (Zwaanswijk et al., 2003).

Second, differences between Latinos and Asian Americans may be found in the types of behavior problems displayed by youth, as manifestations of distress may be culturally modulated (Lopez & Guarnaccia, 2000; Weisz et al., 1997). The suppression-facilitation hypothesis suggests that cultural contexts shape socialization practices, which in turn shape idioms of distress among children (Weisz et al., 2006). Compared with children from other cultural backgrounds, Asian youth are more likely to exhibit internalizing problems (e.g., depressed or withdrawn behavior) that are syntonetic with valuation of interpersonal harmony, and less likely to evince externalizing behaviors (e.g., aggression and impulsivity) that represent marked cultural transgressions in interdependent contexts (Weisz et al., 1987). Thus, to the extent that positive academic functioning and internalizing presentations are more common among Asian American children compared with Latino youth, adult gatekeepers of SBMHs may be less likely to recognize mental health problems among Asian American students. Given the range of similarities and differences between Asian American and Latino families and students, examination of potential disparities between these groups in SBMH services is warranted.

The Gateway to Success Program

The Alhambra Unified School District (AUSD) is an urban public school district in California that served 18,541 students in 2009–2010, including 7,708 (41.6%) Latino, 9,586 (51.7%) Asian American, and 652 (3.5%) non-Hispanic White students. In the district, 5,514 (29.7%) are English language learners, which includes 1,822 (9.8%) native Spanish speakers, 1,769 (9.5%) native

Cantonese speakers, 871 (4.7%) native Mandarin speakers, and 472 (2.5%) Vietnamese speakers. The district serves a high proportion of low-income families, with all schools being Title I eligible. Across the campuses between 70%–81% of students receive free or reduced cost lunch. As in national data, there are notable achievement gaps between racial/ethnic groups in AUSD. Data from 2009–2010 reveal that 43.7% Asian American students scored at the Advanced Performance Level in Language Arts compared with 16.6% of Latino students. Conversely, significantly higher percentages of Latino students scored at the Basic, Below Basic, and Far Below Basic Performance levels than Asian American students.

Federal funding through the Safe Schools/Healthy Students program was secured in 2005 to install a comprehensive SBMH system. The goal of the Gateway to Success Program (Gateway) was to increase access to quality mental health care by developing research-informed approaches to link the school system with the local mental health resources. Gateway represents a collaboration between leadership from the school district, community agencies, and higher education partners. The Mental Health Integration Team (MHIT) conducts strategic planning, expands partnerships, oversees program implementation, and monitors outcomes. Advisory boards that include both student and parent representation provide ongoing feedback to the MHIT to ensure program responsiveness to the cultural and linguistic needs of district families. At the outset of the program, the MHIT assessed service availability through Resource Mapping and Gap Analysis (Adelman & Taylor, 2006) to identify existing services and gaps in those services. The MHIT thus identified and partnered with community agencies with the capacity to provide services to culturally diverse families. Periodic Resource Mapping was employed to evaluate progress and allow for responsive reallocations to sustain adequate reach.

Thus, although federal funding was used to develop the SBMH system infrastructure, all service provision is now sustained without grant funding through community partnerships. Currently, over 20 community partner agencies provide SBMH through contracts with AUSD. Families who are Medicaid eligible can be served by providers in local public community mental health agencies. Uninsured or underinsured youth receive SBMH services through contracts with nearby universities with clinical psychology train-

ing programs delivered by trainees supervised by licensed professionals. During, 2009–2010, 1,413 students in Kindergarten through Grade 12 (K–12) were referred to Gateway SBMH. These referrals resulted in 1,004 students being linked to treatment and served by 101 providers (64% were providers from publicly funded mental health agencies, 34% were supervised trainees in mental health fields).

The School Site Team (SST) on each of the 17 campuses is composed of school staff (including teachers, administrators, and support personnel), delegates from community partner agencies, local law enforcement, and site administrators. The SST is tasked with managing school-wide positive behavior support, addressing emergent family/student crises, coordination of universal and early interventions on campus, and monitoring of students identified as at risk to facilitate their engagement in services. Figure 1 depicts the process and agents involved in the referral, linkage, and evaluation in the Gateway Program. Referrals may be initiated by school staff, parents and students. District-wide staff training was provided on the identification of student mental health needs and referral procedures. There is an annual training for all district personnel on procedures for documenting concerns about students and contacting their SST to initiate a referral. In addition, school administrators and staff are routinely trained on identifying at-risk student behavior (signs and symptoms of internalizing and externalizing behavior problems), suicide risk assessment and steps for intervention, and assessing and responding to threats to student or campus safety. In addition to this, board policy requires annual training in all of these areas, with respect to student support and safety.

Once referrals are made, the SST team triages and assigns each referral to an appropriate provider. The SST leader contacts the family, introduces the service, assesses for third party payment, and prepares the family for the subsequent contact with the service provider. The provider then contacts the student's caregiver to offer and coordinate care. To evaluate the impact of this SBMH platform, a referral tracking surveillance system was developed to track referrals and service linkages. This system provides the dual function of monitoring individual cases from referral to service termination and permitting evaluation of the program's impact on service capacity, access, and timeliness.

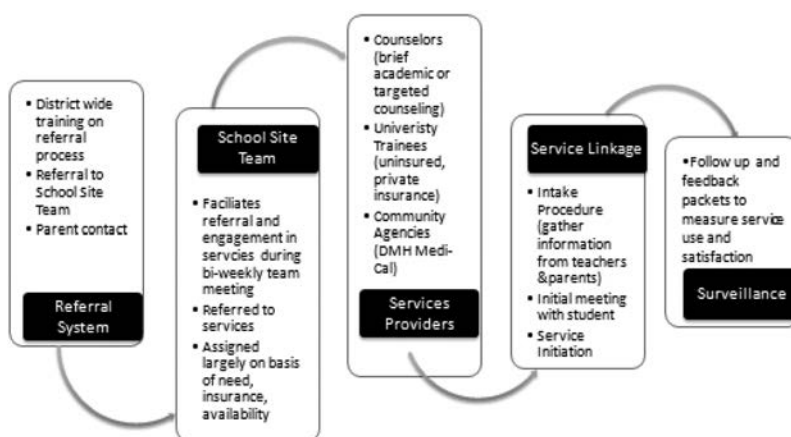


Figure 1. Design features of Gateway to Success to promote reach of school-based mental health services.

Thus, the Gateway program was built to extend the reach of SBMH to traditionally underserved communities that form district enrollment. This was accomplished by finding ways to limit gaps in access due to third-party coverage, connecting to community resources with linguistic capacity to serve district families, and covering a sizable population with few dedicated district mental health personnel. This infrastructure was achieved through training existing school personnel in the referral process, active outreach to community stakeholders, and coordination of care with public sector community mental health providers and higher education training programs. Although prevention of racial disparities was not an explicit goal, it was an implicit goal to create level access across families from diverse backgrounds.

The Current Study

The aim of this article was to critically examine success of the Gateway program in broadening the reach of SBMH services equitably across a diverse student population. We examined data gathered through district student mental health needs assessments and the referral tracking surveillance system to examine patterns of SBMH reach, access, and parity in SBMH. In particular, we were interested in whether the increased access and coordination of SBMH services in the Gateway Program resulted in parity in care across diverse groups in the school district. As such, we examined racial/ethnic differences in rates of student mental health need, rates of referral into care, and rates of child/family engagement in SBMH services. Thus, we contrasted rates of assessed student mental health need and penetration of services for Asian American and Latino families in AUD.

Method

Data Sources and Measures

Student mental health needs assessment. Estimates of student mental health need were derived from screening measures administered to a stratified random sample of students in Grades 5 through 12. A random sample of classrooms stratified by grade and school campus was drawn. All students in selected classrooms present on the date of data collection participated. They were instructed to anonymously complete a mental health screener during noninstructional class time. Given that this was routine district needs assessment and the anonymous nature of the screening, requirements for parental consent were waived by the governing Institutional Review Board. Classrooms were sampled across all 17 schools. Data from all students present in class on data collection dates was received, yielding a total sample of 1,258 students (9.4% of students in these grades). In the current study, we excluded data from students who self-identified as non-Hispanic White (40, 3.2%), or as other race/ethnicity (267, 21.2%), or who declined to state race/ethnicity (16, 1.3%). These groups are not well represented district-wide, and accordingly were too few in the screening and referral samples to provide reliable estimates of mental health need and to draw conclusions about parity in care. Thus, our sample included 990 (78.6%) students who self-identified as Asian American (56.7%) or Latino (43.3%). From the screening sample, students were asked to have their primary caregiver anonymously complete the parallel parent form

of the screener and return it to school. The parent screener was available in English, Spanish, and Chinese (traditional and simplified). The response rate among parents was 57.9% for Asian American students, and 68.3% for Latino students. Of note, although the parent forms were available in Chinese, which was the most commonly used home language among Asian American students in the district, translations were not available in other Asian languages and that may have affected the rate of response among non-Chinese families.

Students and parents completed the *Strengths and Difficulties Questionnaire* (SDQ; Goodman et al., 2000) to assess conduct problems, hyperactivity, emotional symptoms, peer problems, and prosocial behaviors for children ages 4 to 17. The SDQ includes 25 items which are assessed using a Likert scale. Total administration time is 5 min. The SDQ has been normed on a nationally representative sample with demonstrated test-retest reliability (.62), and concurrent validity with the Child Behavior Checklist total score ($r = .70$) and Youth Self Report total score ($r = .74$). Internal consistency in the current sample was adequate. Cronbach's alpha's ranged from .54 to .67 for the behavior problem subscales (emotional symptoms $\alpha = .66$, conduct problems $\alpha = .54$, hyperactivity $\alpha = .64$). Parent reports revealed similar internal consistency (emotional symptoms $\alpha = .68$, conduct problems $\alpha = .53$, hyperactivity $\alpha = .69$).

Parents also completed a survey of *Perceived Barriers* to mental health treatment. The 9-item measure developed by the Gateway Program evaluated practical, attitudinal, and informational barriers to seeking mental health services. Parents were asked to rate whether or not each barrier would prevent them from seeking SBMH services. Four items assessed for stigma-related barriers (e.g., "Feeling like I have something to hide"), two for informational barriers (e.g., "Not knowing where to get help"), and three for practical barriers (e.g., "Lack of transportation"). An iterated maximum likelihood exploratory factor analysis confirmed extraction of the three factors. The item-factor loadings for attitudinal barriers ranged from .50 to .72; practical barriers ranged from .56 to .76; and informational barriers ranged from .68 to .86. In the current sample, Cronbach's alpha for the full scale was .84, with adequate internal consistency for the subscales as well with alphas ranging from .73 to .85.

Service referral and utilization. Data from the Referral Tracking Surveillance System (RTS) for academic year 2009–2010 was analyzed to examine racial/ethnic differences in rates of referral, service acceptance, and receipt of care district-wide. The RTS includes demographic information including gender, ethnicity, age, primary language spoken at home, grade, parent's marital status, and insurance eligibility along with referral and episode of care data, including number of sessions attended. Rates of child/family engagement were measured by the presence of family/collateral sessions and the total number of sessions attended.

Data Analyses

Chi-square analyses were conducted to assess for racial/ethnic differences in rates of positive screens for student mental health need, rates of referral into care, and rates of child/family engagement in SBMH services among those youth referred to care.

Results

Student Mental Health Need

Analysis of the student SDQ screeners revealed a positive screen rate of 20.3% for clinical problems including emotional problems (6.8%), conduct problems (10.1%), and hyperactivity (9.8%). As shown in Figure 2, there was no significant difference on the overall rate of positive screens between the Asian American students and the Latino students. However, significant differences between Asian American and Hispanic/Latino youth on specific clinical problems were evident. Asian American youth were more likely to screen positive on emotional problems than their Latino counterparts, $\chi^2(1) = 3.410$, $p < .05$. Conversely, Latino youth were more likely to self-report elevated conduct problems, $\chi^2(1) = 5.264$, $p < .05$ and hyperactivity, $\chi^2(1) = 4.383$, $p < .05$.

Results from the parent-reported SDQ revealed that 15.7% of students (K–12) had problems of clinical severity according to parent report. Parent ratings yielded the following positive screen rates: emotional problems (10.8%), conduct problems (6.7%), and hyperactivity (4.2%). Levels of parent-reported mental health need were not significantly different for Asian American versus Latino youth as shown in Figure 2.

Barriers to Mental Health Services

Parents most commonly reported barriers related to lack of knowledge about how to get care (44%–45%) followed by affective barriers related to stigma (19%–38%), and practical access barriers (10%–29%). Latinos parents were marginally more likely to report stigma-related barriers ($OR = 1.17$, $p = .051$), but there were no ethnic differences in practical ($OR = 1.00$, $p = .97$) or knowledge barriers ($OR = .99$, $p = .37$).

SBMH Referral by Race/Ethnicity

The SBMH system resulted in 1,413 referrals of students district-wide in 2009–2010, including 349 Asian Americans and 1,064 Latinos. Of these referrals, 54.8% were elementary school students (K–8) and 45.2% were high school students. Data revealed that 18.6% of students referred were uninsured. Latino families were more likely to be uninsured (22.2%) compared with Asian American families (14.2%), $\chi^2(1) =$

21.48, $p < .01$. Asian American families (62.7%) were more likely to receive Medicaid compared with Latino families (47.9%), $\chi^2(1) = 20.81$, $p < .001$.

Source of referral was recorded in the RTS for 1,367 students recommended for services. Among them, 59.5% were referred by school administrators or staff, 21.4% by teachers, 7.3% by parents or guardians, 6.8% by a counselor/therapist, and 5.0% were self-referred. Chi-square analysis reveal there is a significant relationship between ethnicity and referral source, $\chi^2(4) = 17.66$, $p = .001$. Specifically, Asian American students were significantly more likely than Latino students to be referred by teachers (26.9% vs. 18.6%, respectively, $\chi^2(1) = 11.11$, $p = .001$) but less likely than Latino students to be referred by parents (3.7% vs. 8.2%, respectively, $\chi^2(1) = 7.92$, $p = .005$). There were no ethnic differences in likelihood of referral by school administrators, therapists, or self.

Reason(s) for referral were obtained for 1,352 students by whom multiple reasons could have been endorsed. Behavioral problem (including, school disciplinary action, probation or juvenile justice involvement) was the primary reason of referral for 49.3% of students, followed by academic difficulties (48.3%), mood or affective difficulties (47.8%), family related difficulties (37.2%), peer problems (27.6%), alcohol, tobacco, or drug use (9.6%), exposure to trauma (6.7%), and medical/somatic complaints (4.2%). Latino youth were significantly more likely than Asian Americans to be referred for substance use (11.4% vs. 4%, respectively; $\chi^2(1) = 16.48$, $p < .001$), academic difficulties (50.9% vs. 40.1%, respectively; $\chi^2(1) = 12.33$, $p < .001$), and family related difficulties (39.3% vs. 30.9%, respectively, $\chi^2(1) = 7.82$, $p = .005$). On the other hand, Asian American students were more likely to be referred for services due to problems with peers (35% vs. 25.2%, $\chi^2(1) = 12.55$, $p < .001$). No ethnic differences were found in other reasons of referral.

District-wide data revealed significant racial/ethnic differences in probability of referral to care. Specifically, Asian American students were significantly less likely to be referred to mental health treatment compared with their Latino counterparts, $\chi^2(1) = 642.58$, $p < .001$. As shown in Table 1, Asians American youth were referred to SBMH at a rate of 3.3% as compared with at 14.1% for Latino youth. The odds ratio was 3.79 which was significant at the $p < .001$ level.

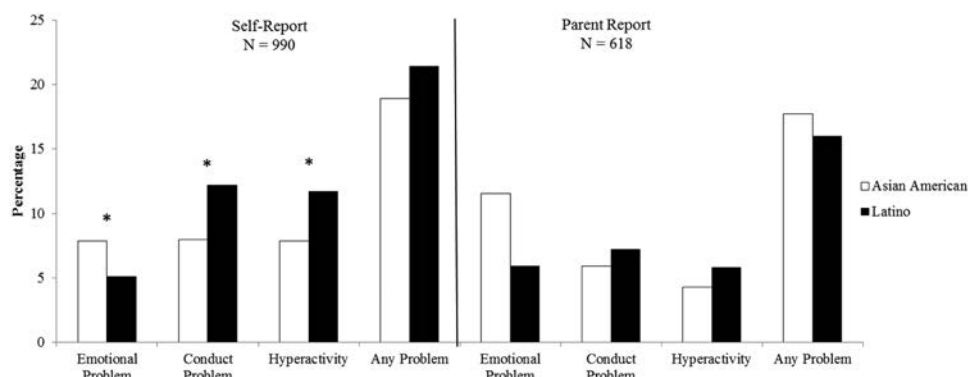


Figure 2. Self-Report and Parent-Report of Student Mental Health Need by Race/Ethnicity.

Table 1
Likelihood of Referral to Gateway by Race/Ethnicity

Referred to Gateways	Race/ethnicity		Total <i>N</i> = 17,294	χ^2	<i>df</i>	Φ
	Latino <i>n</i> = 7,708	Asian American <i>n</i> = 9,586				
Yes	1,064 (13.8%)	349 (3.6%)	1,393 (8.0%)	615.26***	1	0.19
No	6,644 (86.2%)	9,515 (96.4%)	15,901 (92.0%)			

Note. Odds ratio = 3.79, 95% CI [3.35, 4.29]. $z = 20.970$, $p < .001$.

*** $p < .001$.

SBMH Service Acceptance by Race/Ethnicity

Table 2 shows that among those youth referred to care, there was a significant difference between Latino and Asian American youth in rates of service acceptance ($\chi^2 = 6.27$, $p < .05$). However, the odds ratio was not significant at 1.11, with a confidence interval of .90 to 1.35. When offered, 75.0% of families of Latino students accepted SBMH services compared with 67.5% of families of Asian American students.

Session Totals and Family/Collateral Involvement of Youth Served by SBMH

ANOVA analyses did not reveal a significant difference in total number of sessions between 172 Asian American and 604 Latino youths who entered treatment, $t(774) = -1.131$, $p = .26$. On average, Asian youths attended 14.73 sessions ($SD = 12.90$) while Latinos attended 16.16 sessions ($SD = 18.98$). Analysis of family/collateral session attendance by race/ethnicity also revealed no significant differences between the two groups. After initial intake, 24.9% of Asian American students and 28.5% of Latino students had some family/collateral involvement in treatment with no significant difference between groups.

Discussion

SBMH systems have been established as a means of supporting academic, behavioral, and social emotional needs of all students unencumbered by barriers to specialty mental health systems (Flaherty, Weist, & Warner, 1996). This article has described SBMH implementation in a district serving primarily students from more recently immigrated ethnic minority groups. Screening in a stratified random sample revealed that levels of mental health need were in the range of that reported in national samples, approximately one in five students (20.3%) reported elevated emotional problems, conduct problems, or hyperactivity on a widely used

screening measure (Bourdon et al., 2005). Rates of positive screening were slightly lower when parent informant reports were obtained (15.7%). This difference is congruent with previous research that indicates that ethnic minority parents may endorse fewer symptoms than the youth themselves (Lau et al., 2004). Adult caregivers may not recognize behavior problems in their children, or they may witness a different constellation of behaviors in the home context than can be observed in peer or school settings (Logan & King, 2002; Teagle, 2002). In immigrant families, incongruent informant reports may be affected by lower levels of mental health literacy among immigrant parents (Abe-Kim et al., 2007; Caucé et al., 2002) and acculturation gaps between immigrant parents and their children (Fung & Lau, 2010).

Of note, overall levels of mental health need according to parent and youth reports did not significantly differ between Asian American and Latino students in the district. However, there were some notable racial/ethnic differences at the subscale level, with Asian American students being more likely than Latino students to report elevated emotional problems, which correspond to internalizing symptoms of depression and anxiety. This is consistent with previous research and theory suggesting that East Asian values and socialization practices may promote internalized manifestations of distress (Nguyen, et al., 2004; Weisz et al., 1997).

In contrast, Latino students were more likely than Asian American students to self-report conduct problems and hyperactivity, which correspond to externalizing symptoms that may be more likely to be recognized as problematic in school and home settings (Bramlett et al., 2002). Internalizing problems are more likely to go unrecognized particularly in ethnic minority and immigrant families (Gudino et al., 2008; Gudino, Lau, Yeh, McCabe, & Hough, 2009). To the extent that internalizing problems are more likely to be underidentified, these racial/ethnic differences in symptom presentations between ethnic minority groups may ultimately be associated with differential rates of unmet need.

Table 2
Likelihood of Accepting Services by Race/Ethnicity

Accepted services	Race/ethnicity		Total <i>N</i> = 1,274	χ^2	<i>df</i>	Φ
	Latino <i>n</i> = 963**	Asian American <i>n</i> = 311**				
Yes	722 (75.0%)	210 (67.5%)	932 (73.2%)	6.27*	1	0.07
No	241 (25.0%)	101 (32.5%)	342 (26.8%)			

Note. Odds ratio = 1.11, 95% CI [.909, 1.35]. $z = 1.026$, $p = .305$.

* $p < .05$. ** Total *n* is reduced due to missing data.

Consistent with this concern, we found that despite having similar rates of self- and parent-reported mental health need, Asian Americans were very much underrepresented among referrals to SBMH. Although Asian American students comprised 51.7% of district enrollment, they represented only 24.7% of SBMH referrals. In contrast, Latino students comprised 41.6% of enrollment and 75.3% of referrals to care. Overall, 8.0% of district students were referred into Gateway SBMH services. But group-specific rates were strikingly different with only 3.6% of Asian American students referred and 13.8% of Latino students were identified as in need of services. Latinos were 3.79 times more likely to be referred for care compared with Asian Americans.

These findings revealing overall similar rates of mental health need but disparate rates of representation in SBMH are suggestive of possible disparities in identification of mental health need in the SBMH system under study. This difference occurred in the context of a major expansion of care providers and district-wide training of school personnel in the availability of care and procedures for making referrals, all in service of building a culture to promote student wellness through the identification of mental health need. The causes of this disparity cannot be determined given the nature of the data collected. Yet, two sets of hypotheses were considered.

First, we examined whether there may be differential experiences of barriers to receipt of treatment among the ethnic minority groups in the district. In general, ethnic minority parents have been found to be less likely to identify their children's mental health needs (Roberts, Alegria, Ramsey, & Chen, 2005), less likely to view services as potentially effective (Bussing, Zima, Gary, & Garvan, 2003; McCabe, 2002; Thompson, 2005), and less likely to enter treatment to address problems that have been identified (Bussing, Schoenberg, Rogers, Zima, & Angus, 1998; Yeh et al., 2005). These findings suggest a range of possible informational, attitudinal, and cultural barriers to seeking children's mental health services among families of color. Data from our parent survey suggested a widespread lack of knowledge about SBMH services among Latino and Asian American parents, particularly among those reporting mental health need. Caregivers with limited knowledge of mental health services are less likely to accept, enter, and complete treatment when it is offered (Bannon & McKay, 2005; Kazdin et al., 1997). In addition, parents of students most at need were more likely to report all types of barriers to care, further cautioning us that students at highest risk may be most unlikely to get care. Ultimately, only 7.3% of referrals into SBMH were initiated by parents and caregivers.

Yet, there were no racial/ethnic differences in endorsement of perceived barriers to care in the parent survey. Thus, our data do not provide direct support for the interpretation that the observed disparities in referrals to care are primarily the result of differential informational and practical barriers to SBMH faced by families. Indeed, results suggested that once referred to services, rates of treatment attendance and family engagement in sessions were not significantly different between Asian Americans and Latinos. Thus, the Gateway system appeared successful in extending care to those students identified as in need. Further, there was no significant difference in the odds that families accepted services with Asian American parents equally likely to consent to care compared to Latino parents. Previous research suggests that Asian Americans are at particularly low likelihood of entering mental health care, even relative to other racial/ethnic groups also known to underuti-

lize services (Abe-Kim et al., 2007). But once SBMH was offered there was no significant difference in probability of acceptance of care, and once youth entered treatment, episode of care data revealed no racial/ethnic differences in number of sessions received, or collateral and/or family involvement in SBMH services. Thus, our consideration of disparities should largely focus on referral processes in the Gateway program.

Accordingly, a second hypothesis is that adult gatekeepers in the SBMH system may be less likely to recognize and refer Asian American students into care relative to Latino students in need. We have already discussed the possibility that the types of problems manifested in the different racial/ethnic groups may account for a higher rate of visibility of mental health need among Latino students. Emotional or internalizing distress has been shown to be less likely to lead to mental health service utilization among youth in ethnic minority and immigrant families, compared with NHW children and those with U.S. born parents (Gudino et al., 2008, 2009). This may be attributable to lowered tolerance for disruptive behavior and relative acceptability of internalizing behaviors in both home and school settings, particularly among students from interdependent cultural backgrounds. Differential academic functioning may represent another factor rendering the mental health needs in Asian American students less visible relative to Latino students. Consistent with national patterns of achievement gaps, Asian American students in Alhambra Unified School District are more likely than their Latino counterparts to maintain strong academic functioning, as indicated by above average performance on standardized tests. Because academic problems are a strong predictor of referral into SBMH, racial/ethnic achievement gaps may relate to disparities in identification of mental health need. Yet, it is also worth mentioning that teachers were more likely to be the initiator of SBMH referrals for Asian American students compared with Latino students. Teachers accounted for 21.4% of referrals overall; it is possible that training teachers in the recognition of at-risk behavior independent of academic performance holds the promise of identifying mental health need in the classroom in ways that can reduce inequities in identifying need.

Thus, the current examination raises important questions about how to ensure that the implementation of SBMH systems results in equitable and systematic allocation of resources and need identification. First, although anonymous mental health screening was conducted to provide an evidence-based estimate of mental health need, universal screening maintaining student identities was not used to systematically identify mental health need in the district population as a whole. Universal screening has been shown to enhance the likelihood that students with mental health need are ultimately connected to SBMH (Gould et al., 2009). Research is needed to determine whether such screening and feedback response systems can reduce racial/ethnic disparities in SBMH. Second, data are needed to determine whether the nature of presenting problems and levels of academic functioning are directly linked to the observed disparity in referrals to care. Ongoing research in the Gateway to Success program is addressing this question. The current study is limited in providing aggregate level data on student mental health need and referral and service use patterns, and data were not linked at the student-level to determine associations. Thus, although suggestive, the current study cannot yield definitive conclusions about the causes of the disproportionality in referrals to care.

Over time the Gateway Program has increased the identification of at risk students and generated referrals for SBMH services within the district and increased the capacity to service those referrals through a network of providers. Referral rates increased almost 20% between the first and second year of implementation. Identification of at risk students and referral generation are necessary to addressing unmet mental health need especially in ethnic minority populations. The creation of a network of partnerships between the district, higher education, and community agencies, resulting in 1,004 students being linked to treatment in 2009–2010. Yet, evaluations of success are dampened by the observed racial/ethnic disparities in referrals to care. Given that no significant differences in mental health need were revealed upon screening, there is work to be done in addressing factors that lead to disproportionality in referrals. On the other hand, it is encouraging that seven of 10 referrals were ultimately connected to services, and that the rate of service acceptance and dose of treatment received did not appear to differ by race/ethnicity. Although Asian American students were less likely to be identified as in need of care, they were no less likely to be connected to services when they were referred.

In sum, this article is a sobering replication of previous literature revealing racial/ethnic disparities in care. However, this demonstration is notable in that SBMH is often regarded as important avenue to mitigate such disparities through leveling access to care across underserved youth and families. Indeed, through community partnerships, Gateway is able to coordinate care for youth irrespective of insurance status and with community providers with the language capacity to serve immigrant families. Yet, disparities persist and our ability to examine disparities between two ethnic minority groups who face similar barriers helps us generate hypotheses about factors that underlie of risk for unmet need (i.e., higher aggregate academic performance, more internalizing presenting problems). Finally, our study served to isolate the disparities to the problem of referral or need identification, rather than farther downstream in the engagement of families and youth and their persistence in care.

To address these concerns about disparities, multiple steps are being taken. First, depression screening efforts will be initiated to help better identify students with internalizing need and to provide a pathway to care through partnerships with higher education programs with preventive intervention capacity. To the extent that differences in referral rates by group may be a function of types of emotional and behavioral problems manifested, it is hoped that systematic screening will result in better identification of nondisruptive forms of student distress and greater parity of referral rates across groups. As such, annual training on referral procedures will now include system-wide performance feedback on disparities in referral practices. In addition, there will be a continued focus on identifying at-risk youth with greater attention to signs and symptoms that are independent of academic performance markers. Second, we are continuing to outreach to families across the district to disseminate information about student wellness, available services, and improve connections between school and home for all groups. Our Parent University program serves the purpose of connecting parents to the schools and enhancing parents' mental health literacy. We will continue to forge strong relations with our community mental health partners serving Latino and Asian American families to continue to build our bicultural, bilingual services to

increase the reach of Gateway services, particularly once comprehensive screening procedures are in place.

Finally, there are some more general implications that may be gleaned from the development and evaluation of the Gateway Program. This strong rate of penetration of care into the district with over 1,000 students being connected to treatment was accomplished through partnerships with over 100 providers representing community mental health and higher education entities. The SBMH system capitalized on a number of funding streams enabling students without health insurance (or behavioral health care benefits) to be served. This delivery of care could not have been accomplished with district resources alone. Strategic planning guided by principles of Resource Mapping and Gap Analysis (Adelman & Taylor, 2006) was feasible and helped to both identify existing services and fill gaps in care through partnering and collective action by partners all of whom benefitted (i.e., through new contracts that leveraged public funding streams, community based training opportunities for students in graduate programs). Although the initial infrastructure required focused action supported by a federal grant, all subsequent service delivery is sustainable. Such a community-partnered effort is crucial in extending the reach of mental health care into schools to reach underserved youth.

References

- Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., . . . Algeria, M. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: Results from the National Latino and Asian American Study. *American Journal of Public Health, 97*, 91–98. doi:10.2105/AJPH.2006.098541
- Adelman, H. S., Barker, L. A., & Nelson, P. (1993). A study of a school-based clinic: Who uses it and who doesn't? *Journal of Clinical Child Psychology, 22*, 52–59. doi:10.1207/s15374424jccp2201_5
- Adelman, H. S., & Taylor, L. (2000). Shaping the future of mental health in schools. *Psychology in the Schools, 37*, 49–60. doi:10.1002/(SICI)1520-6807(200001)37:1<49::AID-PITS6>3.0.CO;2-0
- Adelman, H. S., & Taylor, L. (2006). School and community collaboration to promote a safe learning environment. State Education Standard. *Journal of the National Association of State Boards of Education, 7*, 38–43.
- Bannon, W. M., & McKay, M. M. (2005). Are barriers to service and parental preference match for service related to urban child mental health service use? *Families in Society, 86*, 30–34. doi:10.1606/1044-3894.1874
- Bourdon, K. H., Goodman, R., Rae, D. S., Simpson, M. S., & Koretz, D. S. (2005). The Strengths and Difficulties Questionnaire: U.S. normative data and psychometric properties. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*, 557–564. doi:10.1097/01.chi.0000159157.57075.c8
- Bramlett, R. K., Murphy, J. L., Johnson, J., Wallingsford, L., & Hall, J. D. (2002). Contemporary practices in school psychology: A national survey of roles and referral problems. *Psychology in the Schools, 39*, 327–335. doi:10.1002/pits.10022
- Britto, M. T., Klostermann, B. K., Bonny, A. E., Altum, S. A., & Hornung, R. W. (2001). Impact of a school-based intervention on access to healthcare for underserved youth. *Journal of Adolescent Health, 29*, 116–124. doi:10.1016/S1054-139X(01)00196-3
- Bussing, R., Schoenberg, N. E., Rogers, K. M., Zima, B. T., & Angus, S. (1998). Explanatory models of ADHD: Do they differ by ethnicity, child gender, or treatment status? *Journal of Emotional and Behavioral Disorders, 6*, 233–242. doi:10.1177/106342669800600405

- Campbell, S. B., & Ewing, L. J. (1990). Follow-up of hard-to manage preschoolers: Adjustment at age 9 and predictors of continuing symptoms. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, 31, 871–889. doi:10.1111/j.1469-7610.1990.tb00831.x
- Cauce, A. M., Domenech-Rodriguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, 70, 44–55. doi:10.1037/0022-006X.70.1.44
- Cummings, J. R., Ponce, N. A., & Mays, V. M. (2010). Comparing racial/ethnic differences in mental health service use among high-need subpopulations across clinical and school based setting. *Journal of Adolescent Health*, 46, 603–606. doi:10.1016/j.jadohealth.2009.11.221
- Duchnowski, A. J., Kutash, K., & Friedman, R. M. (2002). Community based interventions in a system of care and outcomes framework. In B. J. Burns & K. Hoagwood (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp. 16–39). New York, NY: Oxford University Press. doi: 10.1093/acprof:oso/9780195134575.003.0002
- Flaherty, L. T., Weist, M. D., & Warner, B. S. (1996). School-based mental health services in the United States: History, current models and needs. *Community Mental Health Journal*, 32, 341–352. doi:10.1007/BF02249452
- Fung, J. J., & Lau, A. S. (2010). Factors associated with parent–child (dis) agreement on child behavior and parenting problems in Chinese immigrant families. *Journal of Clinical Child & Adolescent Psychology*, 39, 314–327. doi:10.1080/15374411003691693
- Garland, A. F., Lau, A. S., Yeh, M., McCabe, K. M., Hough, R. L., & Landsverk, J. A. (2005). Racial and ethnic differences in utilization of mental health services among high-risk youths. *The American Journal of Psychiatry*, 162, 1336–1343. doi:10.1176/appi.ajp.162.7.1336
- Goodman, R., Ford, T., Simmons, H., Gatward, R., & Meltzer, H. (2000). Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *The British Journal of Psychiatry*, 177, 534–539. doi:10.1192/bjp.177.6.534
- Gould, M. S., Marrocco, F. A., Hoagwood, K., Kleinman, M., Amakawa, L., & Altschuler, E. (2009). Service use by at-risk youths after school-based suicide screening. *Journal of American Academy of Child and Adolescent Psychiatry*, 48, 1193–1201. doi:10.1097/CHI.0b013e3181bef6d5
- Gudino, O. G., Lau, A. S., & Hough, R. L. (2008). Immigrant status, mental health need, and mental health service utilization among high-risk Hispanic and Asian Pacific Islander youth. *Child & Youth Care Forum*, 37, 139–152. doi:10.1007/s10566-008-9056-4
- Gudino, O. G., Lau, A. S., Yeh, M., McCabe, K. M., & Hough, R. L. (2009). Understanding racial/ethnic disparities in youth mental health services: Do disparities vary by problem type? *Journal of Emotional and Behavioral Disorders*, 17, 3–16. doi:10.1177/1063426608317710
- Guo, S., Kataoka, S. H., Bear, L., & Lau, A. S. (2014). Differences in school-based referrals for mental health care: Understanding racial/ethnic disparities between Asian American and Latino youth. *School Mental Health*, 6, 27–39.
- Hawkins, J. D., Catalano, R., Kosterman, R., Abbott, R., & Hill, K. (1999). Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatric Adolescent Medicine*, 153, 226–234. doi:10.1001/archpedi.153.3.226
- Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–1189. doi:10.1176/appi.ps.52.9.1179
- Hofstra, M. B., van der Ende, J., & Verhulst, F. C. (2002). Child and adolescent problems predict DSM–IV disorders in adulthood: A 14-year follow-up of a Dutch epidemiological sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 182–189. doi:10.1097/00004583-200202000-00012
- Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K., . . . Schonlau, M. (2010). Children's mental health care following hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*, 23, 223–231. doi: 10.1002/jts.20518
- Juszczak, L., Melinkovich, P., & Kaplan, D. (2003). Use of health and mental health services by adolescents across multiple delivery sites. *Journal of Adolescent Health*, 32, 108–118.
- 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. *The American Journal of Psychiatry*, 159, 1548–1555. doi: 10.1176/appi.ajp.159.9.1548
- Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *Journal of Child Psychology and Psychiatry*, 38, 1051–1062. doi:10.1111/j.1469-7610.1997.tb01621.x
- Keeton, V., Soleimanpour, S., & Brindis, C. D. (2012). School-based health centers in an era of health care reform: Building on history. *Current Problems in Pediatric and Adolescent Health Care*, 42, 132–156. doi:10.1016/j.cppeds.2012.03.002
- Kodjo, C. M., & Auinger, P. (2004). Predictors for emotionally distressed adolescents to receive mental health care. *Journal of Adolescent Health*, 35, 368–373. doi:10.1016/j.jadohealth.2003.12.005
- Lau, A. S., Garland, A. F., Yeh, M., McCabe, K. M., Wood, P. A., & Hough, R. L. (2004). Race/ethnicity and inter-informant agreement in assessing adolescent psychopathology. *Journal of Emotional and Behavior Disorders*, 12, 145–156. doi:10.1177/10634266040120030201
- Leong, F., & Lau, A. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Service Research*, 3, 201–214. doi:10.1023/A:1013177014788
- Logan, D. E., & King, C. A. (2002). Parental identification of depression and mental health service use among depressed adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 296–304. doi:10.1097/00004583-200203000-00009
- Lopez, S. R., & Guarnaccia, P. J. (2000). Cultural psychopathology: Uncovering the social world of mental health. *Annual Review of Psychology*, 51, 571–598. doi:10.1146/annurev.psych.51.1.571
- Lyon, A. R., Ludwig, K. A., Vander Stoep, A., Gudmundsen, G., & McCauley, E. (2013). Patterns and predictors of mental healthcare utilization in schools and other service sectors among adolescents at risk for depression. *School Mental Health*, 5, 155–165.
- Mandel, L. A., & Qazilbash, J. (2005). Youth voices as change agents: Moving beyond the medical model in school-based health center practice. *Journal of School Health*, 75(7), 239–242. doi:10.1111/j.1746-1561.2005.tb06682.x
- Mason-Jones, A. J., Crisp, C., Momberg, M., Koech, J., De Koker, P., & Mathews, C. (2012). A systematic review of the role of school-based healthcare in adolescent sexual, reproductive, and mental health. *Systematic Reviews*, 1, 49. doi:10.1186/2046-4053-1-49
- McCabe, K. M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal of Child and Family Studies*, 11, 347–359. doi:10.1023/A:1016876224388
- McGee, R., Feehan, M., Williams, S., & Anderson, J. (1992). DSM–III disorders from age 11 to age 15 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 50–59. doi:10.1097/00004583-199201000-00009
- Nguyen, L., Grllyn, F. A., Larke, N. H., Liao, Q., Nguyen, H., & Santiago, R. (2004). Psychiatric diagnoses and clinical characteristics of Asian American youth in children's services. *Journal of Child and Family Studies*, 13, 483–495. doi:10.1023/B:JCSF.0000044729.93879.c2
- Pew Hispanic Center. (2009). *Latinos and education: Explaining the attainment gap*. Washington, DC.

- Roberts, R. E., Alegría, M., Ramsay, C. R., & Chen, I. G. (2005). Mental health problems of adolescents as reported by their caregivers: A comparison of European, African, and Latino Americans. *The Journal of Behavioral Health Services and Research*, 32, 1–13. doi:10.1007/BF02287324
- Slade, E. P. (2002). Effects of school-based mental health programs on mental health service use by adolescents at school and in the community. *Mental Health Services Research*, 4, 151–166. doi:10.1023/A:1019711113312
- Slade, E. P. (2004). Racial/ethnic disparities in parent perception of child need for mental health care following school disciplinary events. *Mental Health Services Research*, 6, 75–92. doi:10.1023/B:MHSR.0000024352.70809.a5
- Snowden, L. R., & Yamada, A. M. (2005). Cultural differences in access to care. *Annual Review of Clinical Psychology*, 1, 143–166. doi:10.1146/annurev.clinpsy.1.102803.143846
- Stephan, S., Weist, M., Kataoka, S., Adelsheim, S., & Mills, C. (2007). Transformation of children's mental health services: The role of school mental health. *Psychiatric Services*, 58, 1330–1338.
- Teagle, S. E. (2002). Parental problem recognition and child mental health service use. *Mental Health Services Research*, 4, 257–266. doi:10.1023/A:1020981019342
- Thompson, R. (2005). The course and correlates of mental health care received by young children: Descriptive data from a longitudinal urban high-risk sample. *Children and Youth Services Review*, 27, 39–50. doi:10.1016/j.childyouth.2004.07.003
- Tseng, V. (2004). Family interdependence and academic adjustment in college: Youth from immigrant and U.S.-born families. *Child Development*, 75, 966–983. doi:10.1111/j.1467-8624.2004.00717.x
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Author, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- Wang, M. C., Haertel, G. D., & Walberg, H. J. (1997). Fostering educational resilience in inner-city schools. In H. J. Walberg, O. Reyes, R. P. Weissberg, H. J. Walberg, O. Reyes, R. P. Weissberg (Eds.), *Children and youth: Interdisciplinary perspectives* (pp. 119–140). Thousand Oaks, CA: Sage.
- Weisz, J. R., McCarty, C. A., Eastman, K. L., Chaiyasit, W., & Suwanlert, S. (1997). Developmental psychopathology and culture: Ten lessons from Thailand. In S. Luthar, J. Burack, D. Cicchetti, & J. Weisz (Eds.), *Developmental psychopathology: Perspectives on adjustment, risk, and disorder* (pp. 568–592). New York, NY: Cambridge University Press.
- Weisz, J. R., McCarty, C. A., & Valeri, S. M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin*, 132, 132–149. doi:10.1037/0033-2909.132.1.132
- Weisz, J. R., Suwanlert, S., Chaiyasit, W., & Walter, B. R. (1987). Over- and undercontrolled referral problems among children and adolescents from Thailand and the United States: The *wat* and *wai* of cultural differences. *Journal of Consulting and Clinical Psychology*, 55, 719–726. doi:10.1037/0022-006X.55.5.719
- Wood, P. A., Yeh, M., Pan, D., Lambros, K. M., McCabe, K. M., & Hough, R. L. (2005). Exploring the relationship between race/ethnicity, age of first school-based services utilization, and age of first specialty mental health care for at-risk youth. *Mental Health Services*, 7, 185–196. doi:10.1007/s11020-005-5787-0
- Yeh, M., Hough, R. L., McCabe, K., Lau, A., & Garland, A. (2004). Parental beliefs about the causes of child problems: Exploring racial/ethnic patterns. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 605–612. doi:10.1097/00004583-200405000-00014
- 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, 65–77. doi:10.1023/A:1023286210205
- Yeh, M., McCabe, K., Hough, R. L., Lau, A., Fakhry, F., & Garland, A. (2005). Why bother with beliefs? Examining relationships between race/ethnicity, parental beliefs about causes of child problems, and mental health service use. *Journal of Consulting and Clinical Psychology*, 73, 800–807. doi:10.1037/0022-006X.73.5.800
- Yeh, M., McCabe, K., Hurlburt, M., Hough, R., Hazen, A., Culver, S., . . . Landsverk, J. (2002). Referral sources, diagnoses, and service types of youth in public outpatient mental health care: A focus on ethnic minorities. *The Journal of Behavioral Health Services and Research*, 29, 45–60. doi:10.1007/BF02287831
- Zins, J. E., Weissberg, R. P., Wang, M. C., & Walberg, H. J. (Eds.). (2004). *Building academic success on social and emotional learning: What does the research say?* New York: Teachers College Press.
- Zwaanswijk, M., van der Ende, J., Verhaak, P. F. M., Bensing, J. M., & Verhulst, F. C. (2003). Factors associated with adolescent mental health service need and utilization. *Journal of the American Academy of Child Adolescent Psychiatry*, 42, 692–700. doi:10.1097/01.CHI.0000046862.56865.B7

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