Ethnic minority youth in youth mental health care : utilization and dropout

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CHAPTER 2

Ethnic differences in utilization of youth mental health care

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Abstract

Objective There is an overall underutilization of youth mental health care (YMHC). It is unknown whether underutilization differs per ethnic group. Therefore, this study is aimed at gaining insight in the effects of ethnicity, age and gender on this utilization.

Design The sample consisted of outpatient children (age 5-10) (n = 1940) and adolescents (age 11-19) (n = 2484) admitted to a Dutch YMHC centre. Ethnic background of the patients (patient registration system) was compared to that of the general population (municipality files). Relative risks on utilization for non-native groups were calculated with natives as the reference group.

Results With regard to children, female children from Moroccan, Turkish and other non-native western descent were less likely to enter mental health care than native Dutch female children. The RR was 0.24 for Moroccan girls, 0.53 for Turkish girls, and 0.60 for girls from other non-native western countries. Male children from almost all non-native groups were also less likely to enter mental health care than native Dutch male children, with the RR's being between 0.43 and 0.65. With regard to adolescents, most ethnic minority adolescents, were as likely as native Dutch adolescents to enter mental health care. An exception were males and females from Morocco and males from Turkey and non-native western countries, who were less likely than native Dutch adolescents to enter mental health care (RR's between 0.61 and 0.80).

Conclusion and discussion Results imply that YMHC is less accessible for children from a ethnic minority background than for children from a native Dutch background. With for adolescents, there is no difference in accessibility between Dutch natives and ethnic minorities. Future research should focus on the reasons for this difference in accessibility. Potential mediators such as socioeconomic status, discrimination, acculturation processes, language barriers should be taken into account.

Keywords: ethnic minorities; underutilization; youth mental health care.

Introduction

The prevalence of psychiatric problems during childhood and adolescence is estimated to be between 10 and 20% (Rutter & Stevenson, 2008). About seven percent of the young population is limited in their functioning to such a degree that treatment is indicated (Rutter & Stevenson, 2008). Several studies done in western Europe (i.e., Norway, England and The Netherlands), have indicated that only an estimated 2.5% finds its way to youth mental health care (YMHC) (Boon et al., 2010; Meltzer et al., 2000; Sytema et al., 2006; Zachrisson et al., 2006). This indicates an overall underutilization of YMHC. Studies in the United States have shown that ethnic minority youths (i.e., African Americans and Hispanic Americans) are less likely to receive mental health care than Caucasian Americans (V. C. Copeland, 2006; Garland et al., 2005), even when they face similar emotional problems (Kodjo & Auinger, 2004). This indicates that the rate of underutilization of YMHC is higher for ethnic minority youth than it is for ethnic majority youth. It is not clear however, whether this accounts for ethnic minority groups in western Europe and whether various ethnic minority groups are equally underrepresented. Therefore, it is relevant to investigate YMHC utilization for various ethnic groups in countries in western Europe, for instance in the Netherlands. The goal of our study is to gain knowledge on the extent of YMHC use among different ethnic groups in The Netherlands and to find explanations for potential differences in utilization. We analyzed the ethnic composition of YMHC patients in a large city in the Netherlands (The Hague) that provides both regular and specialized intercultural care. The following research question was formulated. Are ethnic minority children and adolescents represented differently in YMHC compared to native Dutch children and adolescents?

Method

Population

The information on all youths (age 5-19 years) from the general population and their ethnic backgrounds was drawn from municipality files. In 2009 a total of 126717 youth**s** (5-19 years) lived in The Hague and surrounding areas. All of the 126717 youths were included in our study. Ethnic background was specified as follows: if the country of birth of both parents was the Netherlands (independently of the country of birth of the child), the child was seen as Dutch. If one or both parents were born abroad, the foreign country was taken as the country of origin. If both parents were born abroad but in different countries, the mother's birth country was taken

as the country of origin. The country of birth of the grandparents was not taken into account. A division was made into the largest minority groups (more than one percent of the total population of the area): Dutch, Surinamese, Turkish, Antillean, Moroccan, "Other African countries" and "Other non-native western" and "Other non-native non-western".

De Jutters, a YMHC centre, covers almost all YMHC of The Hague (one of the four major cities of The Netherlands) and its surroundings. All ambulatory settings (including a specific intercultural setting), and the (day-care) clinics were taken into account. In 2009 a total of 5033 patients (5-19 years) were treated at De Jutters. Information about patients ethnic backgrounds was drawn from the patient registration system used by De Jutters. At the beginning of treatment, all patients were asked if they allow that their personal identification data is used for research purposes. Patients' ethnic backgrounds were specified in similar ways to the ethnic background of the general population. The ethnic background of patients at De Jutters was known for 87,9% of the patients (n = 4424), resulting in a sample of 1940 children and 2484 adolescents. No differences in socio-demographic characteristics were found between participants and excluded patients (data available on request).

Statistical Analyses

Patient's ethnic backgrounds (using the patient registration system) were was compared to the general population distribution of the same region. Relative risk ratios (likelihood) of YMHC utilization for ethnic minority groups were calculated with native Dutch youth YMHC utilization as the reference group. The YMHC utilization percentages of native Dutch youths were thus taken as the reference (RR=1) and the YMHC utilization percentages of the ethnic minority groups as the nominator. Age specific (5-10 years vs. 11-19 years) and gender specific (male vs. female) results will be presented.

Results

For female children, the YMHC utilization percentages varied from 0.8 for Moroccan girls (12/1571) to 3.2 for native Dutch girls (341/10783) (table 1), with an overall average of 2.6 (536/21000). As shown in table 1, Moroccan girls, Turkish girls and other non-native western girls all had a significantly smaller likelihood (RR < 1, $p < .00$) of using YMHC than native Dutch girls.

For male children, the YMHC utilization percentages varied from 3.6 for other non-native non-western boys (55/1529) to 8.4 for native Dutch boys (922/10998) (table 1). The overall average of 6.5% (1404/21742) was consistent with the estimated 7% prevalence rate (Rutter & Stevenson, 2008). But even with these higher utilization percentages, the relative risks for almost all ethnic minority boys to use YMHC compared to native Dutch boys (with the exception of the Antillean/Aruban group) were significantly lower (RR < 1, $p < .00$).

The treatment percentages for female adolescents varied from 2.3 for Moroccan adolescents (64/2729) to 3.8 for Surinamese adolescents (162/4247) (table 1), with an overall average of 3.1% (1284/41031). The relative risks in table 1 show that the likelihood for ethnic minority female adolescents to use YMHC was as high as the likelihood for native Dutch female adolescents to use YMHC, with the exception of the Moroccan females (RR < 1, $p = .02$). The likelihood for Surinamese female adolescents to use YMHC was significantly higher than for native Dutch female adolescents (RR = 1.19, $p = .04$)

The treatment percentages for male adolescents varied from 1.9 for other non-native western adolescents (86/4561) to 3.2 for other non-native non-western adolescents (94/2949) with an overall average of 2.8% (1200/42944). The relative risks for most ethnic minority male adolescents to use YMHC were similar to the risks for native Dutch male adolescents. The risks were significantly smaller (RR < 1, $p < .00$ and $p = .04$) for Turkish, Moroccan non-native western male adolescents though.

Table 1: Ethnic background of the YMHC patients compared to the general population of The Hague

	Females				Males			
Ethnic background	Patients (N)	Population (N)	RR	C.I. (95%)	Patients (N)	Population (N)	RR	C.I. (95%)
children (5-10)								
Native Dutch	341	10783	1		- 922	10998	1	-
Surinamese	44	1867	0.75	0.55 - 1.02 (p = .06)	106	1950	0.65**	0.53 - 0.79 (p < .00)
Turkish	29	1726	0.53**	0.36 - 0.77 (p < .00)	81	1795	0.54**	0.43 - 0.67 (p < .00)
Moroccan	12	1571	0.24**	0.14 - 0.43 (p < .00)	67	1677	0.48**	0.37 - 0.61 (p < .00)
Antillean and Aruban	11	480	0.72	0.40 - 1.31 (p = .29)	40	544	0.88	0.65 - 1.19 (p = .40)
Other African	18	871	0.65	0.41 - 1.04 (p = .08)	41	972	0.50**	0.37 - 0.68 (p < .00)
Other western	41	2181	0.60**	0.43 - 0.82 (p < .00)	92	2277	0.48**	0.39 - 0.59 (p < .00)
Other non-western	40	1521	0.83	0.60 - 1.15 (p = .26)	55	1529	0.43**	0.33 - 0.56 (p < .00)
Total	536	21000			1404	21742		
adolescents (11-19)								
Native Dutch	677	21161	1	-	682	22085	1	-
Surinamese	162	4247	1.19*	1.01 - 1.41 (p = .04)	114	4322	0.85	0.70 - 1.04 (p = .11)
Turkish	84	3195	0.82	0.66 - 1.03 (p = .09)	89	3619	0.80*	0.64 - 0.99 (p = .04)
Moroccan	64	2729	0.73*	0.57 - 0.94 (p = .02)	57	2743	0.67**	0.52 - 0.89 (p < .00)
Antillean and Aruban	42	1224	1.07	0.79 - 1.46 (p = .65)	37	1272	0.94	0.68 - 1.31 (p = .72)
Other African	48	1435	1.05	0.78 - 1.39 (p = .76)	41	1393	0.95	0.70 - 1.30 (p = .76)
Other western	127	4323	0.92	0.76 - 1.11 (p = .37)	86	4561	0.61**	0.49 - 0.76 (p < .00)
Other non-western	80	2717	0.92	0.73 - 1.16 (p = .48)	94	2949	1.03	0.83 - 1.28 (p = .77)
Total	1284	41031			1200	42944		

* = significant on a 95% level; ** = significant on a 99% level

Conclusion and discussion

The present study intended to gain insight in the differences between ethnic groups on utilization of YMHC. The main conclusion from this study is that the use of YMHC services was unequally distributed over the different ethnic, gender and age groups amongst children but not amongst adolescents.

During childhood, most ethnic minority girls and boys are less likely to use YMHC than native Dutch boys and girls, despite the inclusion of the intercultural specific ambulatory treatment setting. Similarly, both male and female adolescents were underrepresented in YMHC but there were no differences between ethnic groups. These results indicate that in general, all children (except for native Dutch boys for whom the utilization percentages are about equal to the prevalence rate of psychiatric disorders) and adolescents are being poorly reached by YMHC. The trajectory towards YMHC should be studied in more detail in order to reveal the causes of this underutilization. It has to become clear how psychiatric problems are perceived by the general population, what the differences are on pathways to mental health services, and which perceptions about YMHC are present. Potential mediators such as socioeconomic status, discrimination, acculturation processes, and language issues should be taken into account. Next, the persons or organizations/facilities where help is being sought (primary care workers, community services) should be the focus of future study. Professionals may be biased and judge on behavioural and psychological cues differently, depending on the ethnic background of the patient or the professional, and cultural values and education (i.e., they might have culturally patterned perceptions of problem behaviour versus normal behaviour).

A limitation of the present study is that the study was based on the data of only one institution in one large city in The Netherlands. Therefore we recommend that the study be replicated in other metropolitan settings. Only then can we learn to what extent specific Dutch factors (or even special features of the population of The Hague) may have influenced the results. Finally, characteristics of the Dutch health care system may limit generalizability of the results found in this study.