Increased Mental Health Treatment Financing, Community-Based Organization’s Treatment Programs, and Latino-White Children’s Financing Disparities

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Abstract

Background: Latino child populations are large and growing, and they present considerable unmet need for mental health treatment. Poverty, lack of health insurance, limited English proficiency, stigma, undocumented status, and inhospitable programming are among many factors that contribute to Latino-White mental health treatment disparities. Lower treatment expenditures serve as an important marker of Latino children’s low rates of mental health treatment and limited participation once enrolled in services.

Aims: We investigated whether total Latino-White expenditure disparities declined when autonomous, county-level mental health plans receive funds free of customary cost-sharing charges, especially when they capitalized on cultural and language-sensitive mental health treatment programs as vehicles to receive and spend treatment funds. Using Whites as benchmark, we considered expenditure pattern disparities favoring Whites over Latinos and, in a smaller number of counties, Latinos over Whites.

Methods: Using segmented regression for interrupted time series on county level treatment systems observed over 64 quarters, we analyzed Medi-Cal paid claims for per-user total expenditures for mental health services delivered to children and youth (under 18 years of age) during a study period covering July 1, 1991 through June 30, 2007. Settlement-mandated Medicaid’s Early Periodic Screening, Diagnosis and Treatment (EPSDT) expenditure increases began in the third quarter of 1995. Terms were introduced to assess immediate and long term inequality reduction as well as the role of culture and language-sensitive community-based programs.

Results: Settlement-mandated increased EPSDT treatment funding was associated with more spending on Whites relative to Latinos unless plans arranged for cultural and language-sensitive mental health treatment programs. However, having programs served more to prevent expenditure disparities from growing than to reduce disparities.

Discussion: EPSDT expanded funding increased proportional expenditures for Whites absent cultural and language-sensitive treatment programs. The programs moderate, but do not overcome, entrenched expenditure disparities. These findings use investment in mental health services for Latino populations to indicate treatment access and utilization, but do not explicitly reflect penetration rates or intensity of services for consumers.

Implications for Policy: New funding, along with an expectation that Latino children’s well documented mental health treatment disparities will be addressed, holds potential for improved mental health access and reducing utilization inequities for this population, especially when specialized, culturally and linguistically sensitive mental health treatment programs are present to serve as recipients of funding.

Implications for Research: To further expand knowledge of how federal or state funding for community based mental health services for low income populations can drive down the longstanding and considerable Latino-White mental health treatment disparities, we must develop and test questions targeting policy drivers which can channel funding to programs and organizations aimed at delivering linguistically and culturally sensitive services to Latino children and their families.

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Introduction

Latino child populations are large and growing, and they present considerable unmet need for mental health treatment.1−3 Latino children do not receive crisis care more than Whites,4 but they are considerably less likely to receive outpatient treatment.5 Lower treatment expenditures serve as an important marker of Latino children’s low rates of mental health treatment and limited participation once enrolled in services.2

Poverty, lack of health insurance, limited English proficiency, stigma, undocumented status, and inhospitable programming are among many factors that contribute to Latino-White mental health treatment disparities.6 Cultural barriers to receiving care are present as Latino children’s caregivers are more likely than others to interpret mental
illness symptoms as something other than a mental health concern—sometimes as culturally preferred idioms of distress. Latinos also are less likely to believe that mental illness can be successfully treated, and are more likely to prefer family and community networks over mental health professionals when seeking assistance.6,7 

Latinos make up more than one-third of California’s population, and Latino families are overrepresented, both in California and nationwide, in the State-Federal Medicaid program.8 Medicaid-funded mental health services in California’s diverse counties—Los Angeles county’s population is 10.2 million people yet 11 other counties have populations below 30,0009—are administered by a decentralized state program of 58 highly varied mental health treatment systems; per-capita expenditures for child mental health services vary widely across counties.10 Greater minority representation polarizes spending: systems spending most and least on children’s treatment are more ethnically diverse. Paying for translation services and otherwise accommodating Latino children’s linguistic and cultural service requirements can make them relatively expensive to treat;11 failure to meet linguistic and cultural requirements drives such consumers away from treatment, thereby reducing expenditures on care for that population.

To promote culturally and linguistically-informed responses to the mental health needs of ethnic minority communities, especially in immigrant and non-English speaking communities, some county mental health officials capitalize on the ability of community-based organizations (CBOs) to translate mental health concerns and resources into terms accessible to minority community members.12 County mental health plans engage CBO’s either for direct provision of services or to facilitate cultural adaptation and community access of county-operated culturally and linguistically focused clinics. CBOs are not-for-profit organizations with a community service mission to improve a community’s social, physical, and economic wellbeing. They broker community connections with social services and health care providers, sometimes forming partnerships for health education, screening, outreach, and referral.12 Examining Latino and Asian American adults with Limited English Proficiency, one study found that individuals with Limited English, when treated in such programs, were more likely to receive outpatient treatment and less likely to be treated via emergency services than similar clients served in other settings. Other studies suggest that CBOs’ culturally and linguistically sensitive programs have greater success in bringing Spanish and Asian-language speaking clients into care.13,14

California State mandate obliges county mental health administrators to reduce ethnic minority-white mental health treatment disparities through Cultural Competence Plan Requirements (CCPR): “Each county must develop and submit a cultural competence plan consistent with these CCPR standards and criteria. It is intended to move county mental health systems toward the reduction of mental health service disparities identified in racial, ethnic, cultural, linguistic, and other underserved/unserved populations”15,16

By contracting with linguistically and culturally accessible CBOs, county administrators help to meet this mandate and ensure that language-accessible and culturally-focused mental health treatment services are available to non-English speaking, immigrant and ethnic minority county residents.

By providing funding for low-income Latino families to access mental health treatment for their children, Medicaid’s Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program affords an additional, especially attractive opportunity to meet California’s mandate to reduce mental health disparities.17 EPSDT provides for comprehensive pediatric screening and payment for all medically necessary follow-up care, including inpatient psychiatric care, outpatient therapy, prescription drugs, rehabilitation, and community-based case management.18 State Medicaid programs are required to reach out to eligible families to inform them about benefits, and to provide assistance in making appointments and arranging transportation for EPSDT-related care.19

Local restrictions on families’ use of EPSDT benefits—mental health benefits especially—led advocates to successfully sue state Medicaid programs, and California’s suit20 settled in 1995.21 The settlement assigned administrative authority for administering the EPSDT benefit to the counties’ autonomous mental health administrations. The settlement also loosened medical necessity criteria, removed visit restrictions, and allowed non-psychiatrist providers to bill for services.14,22 Furthermore, California’s State government agreed to pay each county’s 50% share of Medi-Cal (California’s Medicaid program) expenditures for EPSDT services incurred after July 1, 1995. As such, EPSDT-eligible treatment could be provided at no additional cost to a county’s administration. California’s EPSDT mental health expansion increased treatment access, especially in rural counties and in historically low-spending counties,23 increasing outpatient treatment rates, and decreasing emergency services use rates.24

Recognizing the often-overlooked role of treatment systems in explaining disparities,25,26 especially in California counties where resource allocation decisions are made,10 this study investigates systems with contrasting historical responses to meeting Latino children’s special linguistic and cultural treatment needs by evaluating the role of culturally and linguistically focused programs in equalizing Latino-White expenditure inequalities. The study examines systems presenting expenditure disparities, where Whites expenditures initially were greater than Latinos, as well a few systems where Latinos expenditures were greater than Whites.

Our concern here is with Latino-White expenditure disparity reduction, which assumes that Latinos’ and Whites’ expenditures should be equal. However, to expect equality rests on a conservative assumption, because successful treatment of Latino children is likely to be more expensive than treatment of Whites. To successfully engage Latino children and families in treatment, cultural and linguistic hurdles must be overcome including culturally-informed conceptions of mental illness which diverge from professional conceptions and lack of understanding of the treatment process, as well as strong expectations for family
involvement in treatment and ongoing problems of acculturative stress.\textsuperscript{27,28}

Though it parallels an earlier report on EPSDT expansion inequality reduction in outpatient and emergency treatment among African Americans,\textsuperscript{29} this study is more expansive; because culturally and linguistically appropriate programs may be of particular importance in reducing Latino-White mental health treatment disparities, due to more recent immigration and higher rates of limited English proficiency, this report also considers such programs as a potentially significant vehicles by which EPSDT expansion might reduce inequities. Using expenditures as an indicator of mental health treatment and participation in services,\textsuperscript{2} the study evaluates whether expanded EPSDT funding disproportionately benefited Latinos and, accordingly, achieved Latino-White inequality reduction, especially where county mental health plan administrators made use of CBOs with culturally sensitive mental health programs. EPSDT was expanded to increase treatment spending and, for this and other reasons, expenditures roughly doubled both for Latinos and Whites statewide over the study’s course. However, greater proportional increases in spending on Latino youth, if they occur, likely reflect greater expenditure increases for Latinos than Whites.

Theoretically, Latino focused programs are a means of meeting the sociocultural and linguistic treatment needs of Latino children and families; counties providing such services would bill for more treatment of prospective and current Latino child clients, perhaps increasing spending on Latino children. We hypothesized that, when compared with (i) a county’s expenditures before EPSDT-expanded funding, and with (ii) pre-post funding for counties never adopting Latino-focused programs, expanded EPSDT funding would disproportionately increase spending on Latino children where counties operated Latino focused programs. Because Latino-focused programs afford possibilities to consolidate and increase culturally sensitive programming, we also expected proportionally greater Latino spending in both counties spending less on Latinos than Whites pre-EPSDT (disparities), as well as in handful of counties spending more on Latinos than Whites (reverse disparities).

Data Sources

\textit{Methods}

\textit{Data Sources}

The data set includes Medi-Cal paid claims for mental health services delivered to youth under age 18, between July 1, 1991 and June 30, 2007. This data was obtained from the now-dissolved California Department of Mental Health (CDMH). CDMH provided data measuring specialty mental health service use and characteristics of Medi-Cal clients who use specialty mental health services. These files include paid claims for services received, as well as client characteristics: client age, gender, ethnicity, diagnosis, aid codes, and service use. Files were constructed in a manner precluding identification of individual identities in the dataset.

Data to identify culturally and linguistically focused treatment programs were gathered from CDMH provider files containing information on individual providers and treatment programs, the Cultural Competency Plans filed with CDMH by county mental health administrations, and telephone interviews. Data collection procedures are described below.

\textit{Independent Variables}

\textit{EPSDT Settlement Funding}

We assessed quarters before and after the EPSDT lawsuit settlement and created a variable “EPSDT” to assign quarters to pre and post periods of the EPSDT legal settlement. EPSDT was assigned “0” for the quarters before EPSDT legal settlement (Q3 1995) and “1” for the quarters afterwards. This variable captured the extent to which the onset of EPSDT funding was associated with an immediate post-EPSDT response in expenditures and funding disparities.

\textit{Culturally and Linguistically Focused Treatment Programs}

We assessed the presence of culture and language-focused treatment programs by casting a wide net for preliminary identification and then cross-checking supplemental information sources to verify initial entries. First, for each quarter, we calculated the relative number of unduplicated Latino child clients served by every provider organization listed in the county mental health provider database. We did this by identifying providers reporting at least 80% Latino clients per year. From this calculation we identified provider names and prepared a list of candidate programs.

We then consulted cultural competency plans submitted annually to the State Department of Mental Health, which identify culturally focused treatment organizations contracting with county mental health organizations. About 77% of the identified candidate providers were listed in cultural competency plans. All providers listed in cultural competency plans also appeared on our initial list. Further, two-thirds of the programs’ clinicians were listed as bilingual-Spanish-speaking. For the remaining providers on our initial list, we cross-checked with listings from a survey of cultural competence specialists conducted for another study.\textsuperscript{13} If questions remained, we called the provider and directly asked about their mission and their culture and Spanish language treatment capacity. Our final sample included programs appearing on our initial list and having at least one corroborating source.

Since we identified very few Latino-focused programs pre-EPSDT expansion, for statistical reasons, we recorded this variable only during post EPSDT-expansion era. Without pre-EPSDT representation, Latino-focused programs reflect post-EPSDT expansion values only, obviating any need to model any interaction between pre-post EPSDT and Latino-focused programs. Post-EPSDT expansion, we identified counties operating at least one Latino focused program (CULTURALLY/LINGUISTICALLYFOCUSED PROGRAM=yes) at any time, contrasting them with counties...
operating no Latino focused programs (CULTURALLY/ LINGUISTICALLYFOCUSED PROGRAM=no) in that period.

Control Variables

Time Trend

In order to control for any linear trends in inequality reduction, we created ‘‘TREND’. TREND was scored as 0 for the first quarter of EPSDT funding expansion, with quarters assigned negative numbers counting backward from 0 to the first quarter observed and positive numbers counting forward to the final quarter. The presence of TREND controlled for underlying linear processes competing with EPSDT’s expanded funding in explaining our findings.

Clinical Severity

To supplement control provided through random effects estimation and by TREND, we added three measures of the treatment system’s aggregate clientele. These measures are system-wide proportions of children served whose characteristics are likely to be correlated with use and intensity of treatment, and possibly also with Latino representation in county mental health service systems. Due to Latino children’s higher poverty rates, these characteristics might also spuriously influence increasing or decreasing disparities in per-user total expenditures. We calculated aggregate-levels in three indicators of clinical status and community functioning and entered the variables for each county at each quarter during the study period. The variables used to control for variation in clinical severity are listed below.

Disability Status

This variable is defined by whether or not a child’s family qualified for Supplemental Social Security (SSI) payments due to the presence of a mental illness-related condition preventing the child from participating successfully in school, with peers, and otherwise succeeding in children’s customary community activities. This variable provided a control for disparities in the functional severity of children’s problems.

Table 1. Total Treatment Expenditures for Latino and White Children within Caseload: Three Year Means and Standard Deviations.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Mental Health Expenditure</th>
<th>Latinos</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td>FY92/93 - FY94/95</td>
<td>$923 (102)</td>
<td>$1,121 (102)</td>
<td></td>
</tr>
<tr>
<td>FY95/96 - FY97/98</td>
<td>$1,234 (95)</td>
<td>$1,451 (109)</td>
<td></td>
</tr>
<tr>
<td>FY98/99 - FY00/01</td>
<td>$1,619 (265)</td>
<td>$1,703 (196)</td>
<td></td>
</tr>
<tr>
<td>FY01/02 - FY03/04</td>
<td>$1,887 (114)</td>
<td>$2,120 (135)</td>
<td></td>
</tr>
<tr>
<td>FY04/05 - FY06/07</td>
<td>$1,812 (114)</td>
<td>$2,140 (173)</td>
<td></td>
</tr>
</tbody>
</table>

Serious Emotional Disturbance

Children with the most serious diagnoses, including Schizophrenia, Bi-Polar Disorder, and Depression, meet criteria established by California officials to be classified as having Serious Emotional Disturbance (SED). SED children qualify for special programming under state-, federal, and foundation-sponsored initiatives. We recorded CDMH’s designation of children as SED and calculated and entered, for each county and each quarter, aggregate caseload proportions of youth SED status.

Foster Care Placement

Children in foster care have been removed from their homes due to abuse or neglect, and have higher mental health needs and utilization than other youth.30 For each quarter, in each county mental health system, we calculated the proportion of treated children who were in foster care, and the Latino-White inequality with that population.

Dependent Variables

Expenditure Disparities

We focused on inequality reduction – how Latinos’ lesser per-capita expenditures came closer to those of Whites, and how Whites’ lesser per-capita expenditures came closer to Latinos’. To measure inequalities, we identified two groups of systems: (i) systems with more quarters before EPSDT expansion where, on average, Whites’ total expenditures exceeded Latinos’ and (ii) systems with more quarters before EPSDT expansion where, on average, Latinos’ per-capita expenditures exceeded Whites’.

To assess service utilization disparities, we calculated proportional differences between Latinos and Whites in expenditures. Thus, for each county system at each quarter, we divided approved per-client expenditures for Latinos by the approved per-client expenditures for Whites. We then subtracted 1 from the resulting ratio and multiplied this by 100. For example, if $93 was spent for Latinos vs. $100 for Whites, then the Latino-White disparity was: (93/100) – 1 = –0.07 × 100 = – 7. In a context of rising expenditures, when observed over time, a positive coefficient for this variable indicates that Latinos’ expenditures rose faster than Whites’ and a negative coefficient signifies that Whites’ expenditures rose faster than Latinos’.

In view of trends in California toward greater treatment expenditures (see Table 1) -and because the very purpose of EPSDT expansion was to pay for more treatment- we believe that disparity reduction overall is best interpreted as greater Latinos’ expenditure growth. This is operationalized as indication that Latinos’ expenditures rose faster than Whites’ expenditures, not in terms of an alternative possibility permitted by our calculation -that Latinos’ expenditures rose or declined less than declining Whites’ expenditures. However, the possibility remains that, at least in some counties and for some quarters, disparity reduction reflects increases or slower reduction in total per-capita expenditures for Latinos’ than for declining Whites’ expenditures.
Total Mental Health Treatment Expenditures
This expenditure category includes expenditures for the following services.

Outpatient Mental Health Services Expenditures
This is a comprehensive category including visits for assessment, individual or group therapy, collateral contact, medication support, case management, therapeutic behavioral services for reducing mental illness disability and restoring, improving, or maintaining successful functioning.

Emergency Services Expenditures
California’s public mental health system provides two categories of emergency services.

Crisis Intervention in community based settings, including telephone hotlines, walk-in crisis intervention services, mobile crisis teams, and urgent, unscheduled clinical care. Crisis intervention, targeting less serious crises, accounts for roughly 90% of crisis care.4

Crisis Stabilization, a more intensive service, is provided in a hospital or other 24-hour health care facility where institutional confinement opportunities are readily at hand.

Day Treatment Intensive Services (Half Day and Full Day)
This service is a structured, multi-disciplinary program of therapy serving as an alternative to psychiatric hospitalization or confinement in another restrictive setting.

Day Rehabilitation (Half Day and Full Day)
This service is a structured, multi-disciplinary program of therapy and rehabilitation services to restore personal independence and functioning.

Data Analytic Procedures

Sample Preparation and Sample Size
To help to stabilize fractions, we restricted our analysis to counties averaging at least 10 clients per quarter during the pre-EPSDT funding expansion period. We also eliminated a few outlier county-quarters presenting suddenly and extremely shifting values indicative of invalid reporting. The final samples were as follows: For counties spending more on Whites before EPSDT expansion, there were 1695 observations representing 25 counties. For counties spending more on Latinos before ESPDT expansion, there were 408 observations for 6 counties.

Regression Analysis
For county mental health treatment systems observed over quarters (county system-by-quarter) between 1993 and 2005, we regressed the onset of EPSDT funding expansion during the third quarter of 1995, the presence of culturally and linguistically sensitive programming post EPSDT expansion, and other covariates on the proportional difference in expenditures for Latinos versus Whites. We observed systems in the pre-EPSDT expansion era presenting more favorable White-to-Latino expenditures within their aggregates, as well as systems spending more on Latinos than Whites, and assessed how much inequality was reduced post EPSDT expansion.

We included a linear time trend to control for underlying linear trends in inequality reduction due to heightened awareness of inequalities and other extraneous factors, and system severity controls including rates of foster care placement, children’s SSI disability, and SED. Our interrupted time series research with segmented regression analysis – considered especially effective for minimizing the chances of spurious causal inference32 – was sensitive both to immediate EPSDT effects and to shifted trends.

We estimated random-effects regression equations with robust standard errors, where time-varying observations of total expenditure inequalities were nested within counties. Given our coding and modeling, “EPSDT” assessed the immediate effect of the funding expansion in counties with no culturally and linguistically sensitive mental health program, and the “CULTURAL/LANGUAGE-FOCUSED PROGRAM” term assessed incremental inequality reduction for counties offering culturally and linguistically sensitive programming. The linear time trend variable (“TREND”) estimated underlying secular trends and “EPSDT X TREND” captured any shift in trends due to EPSDT funding expansion. Time-varying aggregate covariates indicated variation in aggregate severity: proportions of children qualifying for Medi-Cal because of disability, children indicated to be SED, and foster care placed children.

Results
Table 1 displays total per-capita expenditures for the 15 study years aggregated into three-year intervals. The inflation rate for the United States from 1991 to 2007 was about 65%.32 As total expenditure rose by 100% during the study period, Latino-White disparities declined slightly: Latinos’ spending was 82.3% and 85.0% of Whites’ spending before expanded EPSDT, and 95.1%, 89%, and 85.7% after.

Table 2 and Table 3, respectively, present regression results for disparity and reverse disparity reduction in per-user total expenditures. For counties initially spending more on Whites than on Latinos, regression coefficients post-EPSDT expansion indicated that counties without culturally and linguistically sensitive programs spent proportionally more on Whites than Latinos (β = −0.163**, SE = 0.039). However, compared with counties without culturally and linguistically sensitive programming, post EPSDT expansion counties with culturally and linguistically sensitive programs spent proportionally more on Latinos than Whites (β = .222**, SE = .028).

For counties initially spending more on Latinos than Whites, post-EPSDT expansion counties lacking culturally and linguistically sensitive programming spent proportionally more on Whites than Latinos (β = −.303**, SE = .114). Relative to this, counties offering culturally and linguistically sensitive programming spent proportionally more on Latinos than Whites (β = 188**, SE = .057) post-EPSDT expansion. The coefficient for EPSDT X TREND demonstrated, however, that EPSDT did not appear to create
a significant shift in disparity trends over time for either counties spending more initially on Whites, or counties spending more initially on Latinos.

Another perspective comes from considering the programs’ pre-post disparity reduction in counties adopting such programming. After expansion, for counties spending relatively more on Whites before EPSDT expansion, counties without culturally and linguistically sensitive programming saw proportional spending on Latinos decrease more than Whites. Conversely, disparities counties with culturally and linguistically sensitive programming experienced proportionally greater Latino expenditures (See Figure 1). But, in terms of disparity reduction in adopting disparity counties, culturally and linguistically sensitive programming showed only slightly greater proportional Latino expenditures (0.163 + 0.222 = 0.059), or they showed slightly lower proportional Latino expenditures (–0.303 + 0.118 = –0.115) in counties with reverse disparities pre-EPSDT (See Figure 2). Culturally and linguistically sensitive programming largely served to moderate increasing expenditure disparities.

Discussion

Settlement of California Medicaid’s EPSDT lawsuit provided county mental health treatment systems state funding for children without the usual requirement for matching county funds; the county’s share of increased funding came from the State of California’s coffers. Overall county children’s mental health expenditures markedly increased over the next 15-year period, well beyond the rate of inflation. As they became eligible for new funding, counties and mental health plans were responsible under state statute to address established disparities in provision of mental health treatment for Latino children and other ethnic minority populations. Federal and state law requires that treatment plans in California and elsewhere address language assistance needs of persons with limited English proficiency, and the EPSDT funding treatment opportunity may have provided a vehicle for meeting ongoing obligations.

Results suggest that some county plan administrators may have used newly available funding to spend proportionately

Table 2. Change In Expenditure Disparities toward Latinos in Counties Where More was Spent on White Than Latino Children in their Caseload PRE-EPSDT.

<table>
<thead>
<tr>
<th></th>
<th>β</th>
<th>SE</th>
<th>95% CI</th>
<th>CI</th>
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<tr>
<td>Intercept</td>
<td>0.409</td>
<td>0.411</td>
<td>–0.396 to 1.214</td>
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<tr>
<td>TREND</td>
<td>0.006</td>
<td>0.006</td>
<td>–0.007 to 0.019</td>
<td>0.019</td>
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<tr>
<td>EPSDT</td>
<td>–0.163**</td>
<td>0.039</td>
<td>–0.240 to –0.086</td>
<td>–0.086</td>
</tr>
<tr>
<td>CULTURAL/LANGUAGE-FOCUSED PROGRAM</td>
<td>0.222**</td>
<td>0.028</td>
<td>0.166 to 0.277</td>
<td>0.277</td>
</tr>
<tr>
<td>EPSDT x TREND</td>
<td>–0.006</td>
<td>0.007</td>
<td>–0.019 to 0.007</td>
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<tr>
<td>Serious Emotional Disturbance</td>
<td>0.305</td>
<td>0.390</td>
<td>–0.459 to 1.069</td>
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<tr>
<td>Disability Status</td>
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<td>–0.041 to 0.115</td>
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<tr>
<td>Foster Care</td>
<td>0.092</td>
<td>0.053</td>
<td>–0.013 to 0.196</td>
<td>0.196</td>
</tr>
</tbody>
</table>

* p < 0.05; ** p < 0.01

Table 3. Change in Expenditure Disparities toward Latinos in Counties where More was Spent on Latinos Than Whites in their Caseload Children PRE-EPSDT.

<table>
<thead>
<tr>
<th></th>
<th>β</th>
<th>SE</th>
<th>95% CI</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>0.703</td>
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<tr>
<td>TREND</td>
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<td>0.017</td>
<td>–0.026 to 0.041</td>
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<tr>
<td>EPSDT</td>
<td>–0.303**</td>
<td>0.114</td>
<td>–0.527 to –0.079</td>
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<tr>
<td>CULTURAL/LANGUAGE-FOCUSED PROGRAM</td>
<td>0.188**</td>
<td>0.057</td>
<td>0.076 to 0.299</td>
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<tr>
<td>EPSDT x TREND</td>
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<td>0.016</td>
<td>–0.041 to 0.022</td>
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<tr>
<td>Serious Emotional Disturbance</td>
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<td>0.631</td>
<td>–0.926 to 1.546</td>
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<tr>
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<td>–0.065 to 0.192</td>
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<tr>
<td>Foster Care</td>
<td>0.063</td>
<td>0.036</td>
<td>–0.007 to 0.133</td>
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more on treatment for Latino child clients than for Whites, as descriptive analysis demonstrates an immediate decline in overall expenditure disparities across all counties in the three to four years following EPSDT expansion. The increased culturally sensitive and Spanish-language treatment capacity available in counties contracting with such community-based programs provided an outlet for the additional spending to increase Latino children’s access to, and continuity of, mental health services. However, this disparity reduction proved transitory. The infusion of funds disproportionately affected Latino children immediately but did not translate into a long-term trend. In fact, descriptive statistics suggest that expenditure disparities actually increased again with the passage of time.

For addressing Latino-Whites expenditure disparities, counties in the present study were shown to be notably better
equipped if they collaborated with organizations offering culturally and linguistically sensitive programming. However, the presence of programs did not, even in the short run, appreciably eliminate expenditure disparities. Conceivably, the number and capacities of such programs may limit impact of such programs on Latino-White mental health expenditure disparities.

The present study affirms that culturally and linguistically sensitive mental health programs can demonstrably play a role in moderating or reversing mental health treatment disparities for Latino children and families. In spite of their importance in the mental health safety net, they are minimally studied and inadequately understood. More research is needed to expand understanding about what kinds of mental health care such CBOs deliver, how they deliver it, and how these programs are organized and financed. This type of research will provide knowledge concerning strategies for outreach and engagement into Latino and other ethnic minority communities, and demonstrate how to organize and fund culturally and linguistically appropriate interventions that reach undertreated ethnic minority populations.

Even in the current policy environment, where Medicaid and Medicaid expansion are imperiled, Medicaid funding for children’s mental health services remains less affected than that for adults due to the State Children’s Health Insurance Program (SCHIP). Prior to the implementation of the Affordable Care Act and Medicaid expansion, SCHIP – which provides health insurance for children in families with incomes up to 400% of the Federal Poverty Line – helped to keep children’s uninsurance rates at about 7%. Federal protections for children, such as SCHIP, enjoy more bipartisan support due to the broadly held belief that children are blameless for their financial status, and thus are “deserving” of public support. As such, reductions in children’s funding are less likely than for adults, and increases remain a possibility.

This study demonstrates that increases in funding and reductions in local cost-sharing, along with an expectation that Latino children’s well documented mental health treatment disparities will be addressed, hold potential for reducing mental health access and utilization inequities for this population. Such new funding may be in the form of expanded EPSDT-funding, child mental health-focused Medicaid waivers, state plan amendments, or increases in state general fund allocations.

It is equally notable that channeling these funds to specialized, culturally and linguistically-sensitive mental health treatment programs can play a significant role in reducing inequality of spending within aggregates. To further expand knowledge of how federal or state funding for community based mental health services for low income populations can drive down the longstanding and considerable Latino-White mental health treatment disparities, we must develop and test questions targeting policy drivers which can channel funding to programs and organizations aimed at delivering these services to Latino children and their families.

References

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