Suicide within Children and Adolescents – Cultural Factors to Consider

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Cultural Competence Summit XX
“Supporting Community Defined Practices”
March 15, 2017
Learning Objectives

- Suicide Overview
- Adolescent Suicide Risk and Protective Factors
- Early Prevention and Treatment
- Cultural Factors to Consider
- Suicide Risk Assessment
Suicide: A Global Issue

- Each year, nearly 800,000 people die by suicide.
- Suicide was the second leading cause of death among 15–29-year-olds globally in 2015.
- Only 28 countries report having a national suicide prevention strategy.
- 90% of suicide cases are associated with mental disorders such as depression and substance abuse.

2015; Source: ©World Health Organization
http://www.who.int/mediacentre/factsheets/fs398/en/
2014 Yearly Suicide Rates by Country Per 100,000 persons

Source: © OECD; Organization for Economic Co-operation and Development
https://data.oecd.org/healthstat/suicide-rates.htm
Suicide in the United States

The US is ranked 50th in the world for suicide rates
Understanding Suicide in the U.S.

• In 2014, 42,773 U.S. citizens died by suicide, compared to 41,149 in 2013, a difference of about 1,624.

• The suicide rate that year was about 13 per 100,000. This is the highest recorded rate in the last 30 years.

• Suicide is the 10th leading cause of death in the United States.

Sources: Centers for Disease Control and Prevention; American Association of Suicidology
Understanding Suicide In the U.S.

- In 2014, whereas suicides accounted for 1.6% of all deaths in the U.S. annually, they comprised 17.6% of all deaths among 15-24 year olds.

- Suicide is the third leading cause of death for 10-14 year olds, the second among persons age 15-34 years.

Source: Suicide in the United States Fact Sheet Based on 2014 Data, American Association of Suicidology
Source: CDC/GOV/ Violence Prevention – Suicide Facts at a Glance 2015
Suicide in Selected Age Groups in the U.S., 2015

- In the U.S., suicide as a leading cause of death is ranked:
  - 3rd among persons aged 10-14
  - 2nd among persons aged 15-34
  - 4th among persons aged 35-44
  - 5th among persons aged 45-54
  - 8th among persons aged 55-64
  - 17th among persons aged 65 and older

Source: 2015, Suicide Facts at a Glance, Centers for Disease Control and Prevention
Understanding Suicide In the U.S.

- In 2015, there were 5,491 completed suicides by youth between the ages of 15-24; 409 among 10-14 year olds

- For every completed suicide by youth, it is estimated that 10-20 attempts are made

Source: U.S.A. Suicide: 2015 Official Final Data, American Association of Suicidology
Timing of U.S.A. Suicides

On average, 1 suicide every 11.9 minutes

- Every 1 hour and 36 minutes, a person under the age of 25 completes suicide
- Each day there are approximately 15 youth suicides
- Each year there are approximately 11 youth suicides for every 100,000 youth

Source: 2015, American Association of Suicidology suicidology.org
Methods of Suicide

- Half (49.8%) of all suicides committed in the US are a result of the use of a firearm; 49.9% for youth

- The next leading method of suicide is hanging, strangulation or suffocation which in 2015 accounted for 26.8% of all completed suicides; this has been an increasing method of suicide among youth in the last decade

- Access to firearms is an important factor in the increases in youth suicide rates.

Source: 2015, American Foundation for Suicide Prevention
## Top 15 ranked states in the U.S. for suicide (2015)

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alaska</td>
<td>27.2</td>
</tr>
<tr>
<td>2</td>
<td>Wyoming</td>
<td>26.8</td>
</tr>
<tr>
<td>3</td>
<td>Montana</td>
<td>26.3</td>
</tr>
<tr>
<td>4</td>
<td>New Mexico</td>
<td>24</td>
</tr>
<tr>
<td>5</td>
<td>Idaho</td>
<td>21.7</td>
</tr>
<tr>
<td>6</td>
<td>Utah</td>
<td>21</td>
</tr>
<tr>
<td>7</td>
<td>Oklahoma</td>
<td>20.2</td>
</tr>
<tr>
<td>7</td>
<td>South Dakota</td>
<td>20.2</td>
</tr>
<tr>
<td>9</td>
<td>Colorado</td>
<td>20</td>
</tr>
<tr>
<td>10</td>
<td>Arkansas</td>
<td>19.4</td>
</tr>
<tr>
<td>11</td>
<td>Nevada</td>
<td>19.3</td>
</tr>
<tr>
<td>12</td>
<td>Oregon</td>
<td>18.9</td>
</tr>
<tr>
<td>13</td>
<td>Arizona</td>
<td>18.7</td>
</tr>
<tr>
<td>14</td>
<td>West Virginia</td>
<td>18.4</td>
</tr>
<tr>
<td>15</td>
<td>Maine</td>
<td>17.7</td>
</tr>
</tbody>
</table>

(Rates are per 100,000 people)

*Source: 2015, American Association of Suicidology [http://pages.iu.edu]*
Where does California Rank?

- As of 2016, California ranks 43rd in suicide rates in the United States.
- On average, there is 1 death by suicide every two hours in California.
- Suicide is the 11th leading cause of death overall.
- Over twice as many people die by suicide in California each year than by homicide.
- Suicide is the 2nd leading cause of death for ages 25-34 in California.

Source: 2016, American Foundation for Suicide Prevention
https://afsp.org/about-suicide/state-fact-sheets/#California
What about Los Angeles?

- In 2013, there were **779** deaths by suicide in Los Angeles county.
  - More Los Angeles county residents died by suicide than from unintentional drug overdoses, motor vehicle crashes, or homicides.

![Diagram showing suicide statistics](image)

*Source: County of Los Angeles Public Health*

http://publichealth.lacounty.gov/ivpp/
Total Suicides each Year in L.A. County, 2008-2013

Source: County of Los Angeles Public Health
https://admin.publichealth.lacounty.gov/ivpp/docs/5%20Year%20Tables%20Death%202008%202012/Suicide%20Data%20Sheet%202008%202012.pdf
LA County Suicide Deaths
Five Year Trends – By Age

County of Los Angeles, Public Health, 2011
CLINICAL NEEDS FOR:

(Children, Adolescents, Adults and Older Adults)
Suicide does not just happen. Studies show that at least 90% of teens who kill themselves have some type of mental health problem, such as depression, anxiety, drug or alcohol abuse, or a behavior problem. They may also have problems at school or with friends or family, or a combination of all these things. Some teens may have been victims of sexual or physical abuse. Others may be struggling with issues related to sexual identity. Usually they have had problems for some time.

### Suicide Deaths: Rates per 100,000

<table>
<thead>
<tr>
<th>Age</th>
<th>Hispanic Rates</th>
<th>U.S. Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Total</td>
<td>9.81</td>
<td>2.11</td>
</tr>
<tr>
<td>15–24</td>
<td>10.69</td>
<td>3.11</td>
</tr>
<tr>
<td>25–34</td>
<td>11.40</td>
<td>2.09</td>
</tr>
<tr>
<td>35–64</td>
<td>11.98</td>
<td>2.77</td>
</tr>
<tr>
<td>65–84</td>
<td>14.35</td>
<td>2.39</td>
</tr>
<tr>
<td>85+</td>
<td>30.58</td>
<td>0.57*</td>
</tr>
</tbody>
</table>

* Number of deaths too low for precision

Hispanic high school students report higher rates of suicidal behaviors than the general population of U.S. High School Students.

The percentage of Hispanic female students reporting suicidal thoughts and behaviors was higher than That of non-Hispanic White female students and Hispanic male students:

Studies have consistently shown that since 1995 Hispanic adolescent females have higher rates of suicidal thoughts and behavior (but not deaths) than Black or White females.

## Leading Causes of Death for Selected Age Groups, United States, 2013

<table>
<thead>
<tr>
<th>Rank</th>
<th>10-14 years</th>
<th>15-24 years</th>
<th>25-34 years</th>
<th>35-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>All others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unintentional Injuries</td>
<td>Unintentional Injuries</td>
<td>Unintentional Injuries</td>
<td>Unintentional Injuries</td>
<td>Malignant Neoplasms</td>
<td>Malignant Neoplasms</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>2</td>
<td>Malignant Neoplasms</td>
<td>Suicide</td>
<td>Suicide</td>
<td>Malignant Neoplasms</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Malignant Neoplasms</td>
</tr>
<tr>
<td>3</td>
<td>Suicide</td>
<td>Homicide</td>
<td>Homicide</td>
<td>Heart Disease</td>
<td>Unintentional Injuries</td>
<td>Unintentional Injuries</td>
<td>Chronic Low Resp Ds</td>
</tr>
<tr>
<td>4</td>
<td>Congenital Anomalies</td>
<td>Malignant Neoplasms</td>
<td>Malignant Neoplasms</td>
<td>Suicide</td>
<td>Liver Disease</td>
<td>Chronic Low Resp Ds</td>
<td>Unintentional Injuries</td>
</tr>
<tr>
<td>5</td>
<td>Homicide</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Homicide</td>
<td>Suicide</td>
<td>Diabetes Mellitus</td>
<td>Cerebrovascular</td>
</tr>
<tr>
<td>6</td>
<td>Heart Disease</td>
<td>Congenital Anomalies</td>
<td>Diabetes</td>
<td>Liver Disease</td>
<td>Diabetes Mellitus</td>
<td>Liver Disease</td>
<td>Alzheimer’s Disease</td>
</tr>
<tr>
<td>7</td>
<td>Chronic Low Resp Ds</td>
<td>Influenza &amp; pneumonia</td>
<td>Liver Disease</td>
<td>Diabetes</td>
<td>Cerebrovascular</td>
<td>Cerebrovascular</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>8</td>
<td>Influenza &amp; Pneumonia</td>
<td>Diabetes</td>
<td>HIV</td>
<td>Cerebrovascular</td>
<td>Chronic Low Resp Ds</td>
<td>Suicide</td>
<td>Influenza &amp; Pneumonia</td>
</tr>
<tr>
<td>9</td>
<td>Cerebrovascular disease</td>
<td>Complicated pregnancy</td>
<td>Cerebrovascular</td>
<td>HIV</td>
<td>Septicemia</td>
<td>Septicemia</td>
<td>Nephritis</td>
</tr>
<tr>
<td>10</td>
<td>Benign neoplasms</td>
<td>Chronic Low Respiratory Disease</td>
<td>Influenza &amp; Pneumonia</td>
<td>Influenza &amp; Pneumonia</td>
<td>HIV</td>
<td>Nephritis</td>
<td>Suicide</td>
</tr>
</tbody>
</table>

Data Source: Centers for Disease Control and Prevention, 2013
In 2015, there were an estimated **9.8 million** adults aged 18 or older in the United States with a *serious mental illness*.
Clinical Needs

• Approximately 2 million adolescents in the U.S. attempt suicide every year

• Among community samples, as many as 4-8% of adolescents report having made at least one suicide attempt

• Among clinical-based samples 24-33% of adolescents report a history of suicide attempts

Clinical needs continued.....

Attempts requiring medical attention were higher among:

- Hispanic Adolescents: 5%
- Blacks 3.7 %
- Whites 1.7 %
Non-Fatal Suicide Attempts

• Among adults 18 and older in the United States during 2013:
  ▫ An estimated 9.3 million adults reported having suicidal thoughts in the past year.
  ▫ An estimated 2.7 million people made a plan about how they would attempt suicide.
  ▫ About 1.3 million adults attempted suicide within the past 12 months.

• Among students in grades 9-12 in the U.S. during 2013:
  ▫ 17% seriously considered attempting suicide in the past 12 months.
  ▫ 13.6% made a plan about how they would attempt suicide.
  ▫ 8% attempted suicide one or more times.

Source: 2015, Suicide Facts at a Glance, Centers for Disease Control and Prevention
Adolescent Suicide Risk Factors
Adolescent Suicide Risk Factors:

- Previous suicide attempt
- Presence of a psychiatric disorder:
  - Depression
  - Bipolar Disorder
  - Substance Use/Abuse
  - Comorbidity
- Family history of suicide
- Exposure to other’s suicidality

Source: American Association of Suicidology, Youth Suicide Fact Sheet, 2009
Suicide Risk Factors Continued......

• Significant changes/losses
  Abuse (physical, emotional, sexual)
  Impulsivity, aggressivity, rage, bullying

• Family loss or instability; significant family conflict (domestic violence, parent’s divorce)

• Thoughts of suicide expressed; continuous talk of death or dying

Source: American Association of Suicidology, Youth Suicide Fact Sheet, 2009
Substance Abuse

- Multiple risk behaviors, e.g., substance use and risky sexual behavior, are associated with high risk of suicide behavior.

- Alcohol consumption is estimated to cause adolescent males to be up to 17 times more likely to attempt suicide, and females three times more likely to attempt suicide (Groves et al., 2007)

- Binge drinking is associated with suicide attempts, even after controlling for depressive symptoms, especially for adolescents aged 13 or younger (Aseltine et al., 2009)

- Smoking is associated with four times higher risk of suicide attempt in adolescents admitted to a psychiatric hospital (Bronisch et al., 2008)
Abuse

• Those with history of physical abuse were 5 times more likely for non-injurious attempt, and 12 times more likely for an injurious attempt (Bensley et al., 1999)

• Sexual abuse is more strongly related to suicide attempt in males: 52% of male rape victims had attempted suicide, compared to 22% of female rape victims (Evan et al., 2004), and under low condition of social support (Esposito & Clum, 2002)
• Among high school students, those with history of sexual abuse were 12 times more likely to make a non-injurious suicide attempt, and 47 times more likely to make an injurious suicide attempt (Bensley et al., 1999)

• Child sexual abuse is a risk factor for both suicide and non-suicidal self-injury (NSSI)

• Being older when abuse was detected, and suffering from multiple perpetrators were associated with higher suicide risk (Plunkett et al., 2002)
**Socioeconomic Disadvantage**

- Higher suicide rate is associated with poverty, discrimination, lower educational level, high school dropout rate, and community violence.

**Delinquency**

- Delinquent youth are 5 times more likely to have seriously considered suicide, made a suicide plan, 10 times more likely to have attempted suicide, and 14 times more likely to make attempts requiring medical treatment (Thompson et al., 2006)

- Female delinquents at greater suicide risk than delinquent males.
Lesbian, Gay, and Bisexual youth

- Rates of attempt are higher in LGBT youth (ranging from 20%-40%), but completed suicide is comparable to heterosexual youth (McDaniels et al., 2001)

- Twice as likely to have suicide ideation, intent, or plan, three times more likely to make a suicide attempt, and 4-6 times more likely to make a serious attempt requiring medical treatment (Fergusson et al. 1999; King et al., 2008; Marshal et al., 2011; Bagley & Tremblay, 2000)
Acculturation

- Disparities in acculturation between the adolescent and their immigrant parent may contribute to higher suicide risk in Latino adolescents in a number of possible ways:
  - Discrepant value systems may contribute to tension, communication difficulties, and family crisis (Zayas et al., 2005; Zayas & Pilat, 2008)
  - Reduces the immigrant parent’s capacity to provide support and influence toward adaptive choices (Rhodes, Contreras, and Manglesdorft, 1994)
  - Compromises the perceived mutuality (bi-directional exchange of feelings, activities, and thoughts) of girls with their mothers (Zayas & Pilat, 2008; Turner et al., 2002)
Paradoxically, increasing assimilation to the mainstream culture may increase the individual’s vulnerability to suicide (Wendler, Matthews and Morelli, 2012). Possible reasons include:

- Assimilation may remove the protection afforded by the membership in the minority subculture.
- Increase social disruption and feelings of normlessness.
- Result in a state of marginality in which the individual feels isolated because he or she is unaccepted in either culture.

Loneliness and a sense of alienation appear to play major role in Latina suicide attempts (Zayas et al., 2010). These girls feel that they cannot connect with someone who will understand what they are experiencing; they belong neither to the culture of their parents nor to the broader culture into which they are inserted.
Warning Signs!

A Suicidal Person May

! Talk about suicide, death and/or no reason to live
! Be preoccupied with death and dying
! Withdraw from friends and/or social activities
! Have a recent severe loss (relationship) or threat of one
! Experience a drastic change in behaviors
! Lose interest in hobbies, work, school, etc.
! Make final arrangements: a youth may give away valuable belongings
Warning Signs (cont)

! Have attempted suicide before
! Take unnecessary risks: be reckless, and/or impulsive
! Lose interest in their personal appearance
! Increase their use of alcohol or drugs
! Express a sense of hopelessness
! Be faced with a situation of humiliation or failure
! Have a history of violence or hostility
! Have been unwilling to “connect” with potential helpers

Source; American Association of Suicidology, 2003
Suicide Risk Assessment
I. Assess the following:

1. Frequency
2. Intensity
3. Duration of the client’s suicidal ideation
   \[\text{Source: American Association of Suicidology 2010; Rud 2006; Sullivan \\& Borger, 2009}\]

II. Assess risk/protective factors:

1. Physical illness, HIV/AIDS, cancer
2. Physical, emotional, sexual abuse
3. Psychiatric diagnosis, depression, substance abuse
4. Previous attempts
5. Stressors
6. Immigration
7. Acculturation
   \[\text{Source: AAS 2010, Klesspies 2009}\]
III. Determination of client’s level of risk:

1. Low risk- out-patient treatment
2. Moderate risk- address risk factors, close follow up
3. High risk- hospitalization with suicide precaution.
4. Extreme high risk - hospitalization with suicide precaution

Obtain any available records/collateral information family, previous treatment provider, friends if possible
Source: American Association of Suicidology 2010; Van or den 2010

IV. Determination of risk is made:

1. Emergency plan
2. Client safe
3. Monitoring the risk level
4. Emergency or crisis respond plans
5. Social, family, friends identify

Source: American Association of Suicidology 2010; Toimer 2005
V. Notify and involve other people:

1. Obtain client’s consent to notify;
   a) Treatment providers
   b) Family members/extended family members
   c) Significant person for client., i.e., Teacher, Coach
2. Church community members

Source: American Association of Suicidology 2010; Sullivan & Bonger 2009

VI. Documentation:

1. Professional liability
2. Monitoring the client’s risk and treatment progress
3. Direct quotations from the client and copies of any safety plans should be included
4. Collateral with treatment providers
5. Client progress

Source: American Association of Suicidology 2010; Rudd 2006
VII. Low concerning suicide:

1. Standards of care

2. Ethical obligations pertaining to the assessment and treatment of suicidality

3. Knowledge of the legal and ethical responsibilities—structure, documentation

Source: AAS 2010; Rudd 2006
Latina Youth Program (LYP) Program Goals

- Increase youth/family/teacher/community awareness of the high-risk youth behaviors associated with Latina suicides and/or attempts: Done through Presentations.

- Assist family in becoming empowered to address key high-risk behaviors of suicide and substance abuse in their adolescent daughters: Done through Parenting Courses and Educational “Platicas”

- Decrease stigma within the Latino community regarding the use of mental health and substance abuse treatment services

- Increase direct mental health services and substance use/abuse treatment service accessibility to Latina girls and their families

*Focus of Treatment is Early Prevention and Intervention*
Program Approach

Despite varying levels of acculturation, Latinos’ are generally referred to as “family oriented”. Research conducted by COSSMHO (1999), evidenced that the majority of Latino Adolescents stated that they would turn to their mother, father, or sister, when they have a problem.

_Pacific Clinics Latina Youth Program has adopted the cultural values of familismo, Respeto, Collectivismo, and Personalismo (Maternal & Child Health Bureau, 1999) in its approach to prevention._

Clinical Considerations

**Familismo**

- Immediate and extended members are the “backbone” of the community.
- Latino Culture values maintaining positive relationships with family members.

*IMPORTANT*: These relationships are viewed to be preventative and protective factors in the lives of young women and men, thereby reducing the incidence of high-risk behaviors that may lead to suicide.*

- The program (LYP) emphasizes familismo in both peer and parent groups in discussing the value of positive communication and mutual respect.
Collectivismo

- The nature of family values are extended into the community.
- Research shows that Latinos have a preference to work in groups and generally live in close knit communities.
- Mexican-American students thrive when working with others in groups, especially when involved in goal attaining activities.
- Collectivismo is demonstrated in the peer groups offered at Pacific Clinics.
Personalismo

• Latinos place great value on interpersonal relationships, young people, particularly those in middle school may turn to families for advice.

• Program Staff will encourage youth participants to seek support and advise from significant others in their lives as opposed to relying on negative peer influence in their decision making.
Respeto

- Emphasis is placed on social worth, bestowing ultimate decision making power on authority figures.
- The values of respect, positive communication, commitment, and appropriate expression of feelings are taught to program youth.
- Parents are provided with education in understanding the developmental needs of youth in establishing their autonomy as well as supported in trusting their parental skills thereby regaining appropriate control within the family system.
Although there are generational differences when it comes to religious identification for Mexicans living in the United States, Hinojos-Gallardo (2011) found that 83.2% of Latinos reported practicing or at least following Catholicism, while another 14% self-identified as Protestant. Roman Catholicism plays an important part in the life of Latino Families and is an important source of identify formation, especially for recent Latino immigrants. Catholicism helps shape beliefs and values around cures for physical and mental illness as religious practices such as prayer, confession, pilgrimages, and personal offerings all play an important part of healing (Walsh, 2009; Wright, 2009)
Marianismo and Machismo

Marianismo can be seen in many different ways in a Latino family, including by a mother staying at home to take care of the children and the family’s needs. Hernandez (2008) notes that up to 92% of children from Mexican immigrant families have a working father, but are also one of the immigrant groups that is least likely to have an employed mother. Thus, teachers have an opportunity to meet with at least one parent when a concern, such as behavioral changes occur, in order to intervene promptly. On the other hand, because a large percentage of Latino mothers stay at home, and even if they work are primarily responsible for taking care of the children, fathers are likely to be working at least one job.
Marianismo and Machismo, continued…

The concept of Machismo is an important part of Latino father’s identity, which calls for him to play the key role in his family’s life as the provider and protector of his wife and children. Torres (1998) described Machismo as “complex interaction of social, cultural, and behavioral components forming male gender-role identity in the sociopolitical context of the Latino society.” This concept greatly influences the entire family regarding their view of mental and physical health.
Treatment
Cultural Factors/Elements Integrate Outreach Engagement, Assessment and Treatment

In the engagement process and throughout therapy, clinicians need to remain attentive to the formalities expected in social interactions such as:

Spending extra time in the process of family engagement with Latinos while keeping the most prevalent and identified values in mind is crucial. Some of these values are:

- Personalismo (Personalism or Familial Self)
- Familismo (Familism)
- Collectivismo/Communidad (Collectivism/Community)
- Respeto (Respect)
- Simpatia/Amabilidad (Kindness/Friendliness)
- Confianza (Trust)
- Marianismo/Machismo
- Spiritualidad/Religion (Spirituality/Religion)
- Fatalismo (Fatalism/Fate)
Relationship between Culture and Behavior

Gloria Gonzales, MFCC
Cultural Modifications During Engagement

- Build rapport by being attentive to cultural orientations. For many families, social agencies can be intimidating and frightening depending on previous interactions with Mental Health providers or “the system,” in which they may have experienced stigmatization or other forms of discrimination.

- Conducting a thorough and culturally modified assessment at the onset of treatment can help engage the particular family system and keep the family in treatment (De Arellano, 2005).
Cultural Modifications during Engagement (continued)

- Clinicians need to understand & honor the need for families to continue the engagement process so that they may feel connected to the therapist throughout the treatment.

- Making the first session count: Remember to meet the family where they are and assist them to leave the first session with **HOPE** that therapy will help.

- Asking questions about family background, cultural beliefs, expectations, and the key constructs addressed.
TREATMENT AND THE IMPORTANCE OF ENGAGEMENT

- The initial session is primarily used to engage the client/caregiver(s)/family in the program and to form a therapeutic relationship with them.

- “Service Providers working with Latinos must become familiar with Latino values and incorporate them into their treatment plans in order to provide the most efficacious and culturally sensitive treatment to these families.” (www.Chadwickcenter.com accessed on 5-15-10).
Treatment

• **Family-Focused Treatment:** We can not treat the child if we are not treating the entire family. Studies have shown that the child has a better prognosis when parents are actively involved in the treatment.

• **Interventions:** All services offered in English & Spanish
  
  ‣ Individual/Family therapy
  
  ‣ Case-Management Support Services
  
  ‣ Psychiatric Services (when appropriate: important to educate and provide needed support in order to minimize fears re: stigma about receiving these services)

  ‣ **Group Therapy:**
    • Adolescent Process Peer Groups (positive peer support = good prognosis)
    • Parent Educational Groups
    • Parent Process Groups
    • Parenting Classes
Summary and Conclusions

**Quality of Care**

- Integration of treatment; Health, behavioral, Substance use
- Reduce disparities; Access, utilization, retention
- Training; Clinical interventions and cultural factors
Together we can make a difference!