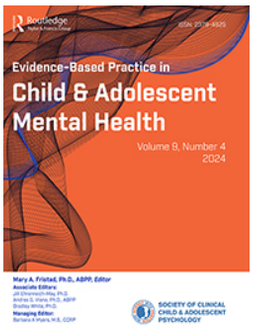

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EVIDENCE-BASED PRACTICE IN CHILD AND ADOLESCENT MENTAL HEALTH
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What Does Diversity Mean to You? Perspectives from Community Mental Health Staff

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ABSTRACT

Background: Although celebrating and promoting diversity is a guiding principle of the mental health care professions, there is no shared, explicit specification of what diversity means to members of the mental health workforce.

Objective: This study explored how community mental health staff conceptualize diversity and report integrating multicultural considerations into their clinical practice.

Method: Community mental health staff ($N = 55$; 73% Master's level; 44% Hispanic/Latine, 29% non-Hispanic White) serving predominantly low-income, Hispanic/Latine youths and families completed a semi-structured interview that queried, "What does diversity mean to you as a mental health professional?" Responses were coded for: mentions of various aspects of diversity (e.g. ethnicity, race, gender identity); the extent to which the participant described sociocultural influences on beliefs and behaviors; and the extent to which the participant described incorporating sociocultural considerations into clinical practice.

Results: Staff described an average of 3.30 ($SD = 1.89$) aspects of diversity – most commonly culture, ethnicity, and race. Staff varied in the extent to which they described sociocultural influences on beliefs and behaviors, such that most staff seemed to comprehend that social and cultural contexts influence mental health but did not elaborate with details or examples. Staff also varied in the extent to which they described incorporating sociocultural considerations into their clinical practice, such that most staff seemed to consider sociocultural factors but did not describe how these considerations influence their case conceptualizations or treatment plans.

Conclusion: Findings suggest that staff have foundational multicultural knowledge and may benefit from more concrete guidance on how to provide multiculturally competent mental health care.

Over recent years, there have been increasing calls and commitments to promote *diversity* across mental health disciplines, as part of concerted diversity, equity, and inclusion efforts. For example, the American Psychological Association (APA) issued a formal apology in October 2021 for its role in "promoting, perpetuating, and failing to challenge *racism*, *racial* discrimination, and human hierarchy in the United States" (American Psychological Association [APA], 2021). In July 2022, APA released an action plan that outlined priority actions for advancing "*racially* conscious knowledge production and scholarship," "health equity in *communities of color*," "efforts to promote an equitable, diverse, and inclusive work environment," "*racially* conscious and equitable training [of psychologists]," and "efforts that work to address *racial* inequities within education environments" (American Psychological Association [APA], 2022). Similar initiatives are evident in other specialties including marriage and family therapy (American Association for Marriage and Family Therapy, 2020) and social work (National Association of Social Workers, 2022). Although these ongoing and planned actions to promote ethnic-racial diversity are unquestionably admirable and reflect important progress for the field, ethnicity and race are only two aspects of diversity. As noted in the current version of the

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Multicultural Guidelines, professional psychological practice requires consideration of "contextual factors and intersectionality among and between reference group identities, including culture, language, gender, race, ethnicity, ability status, sexual orientation, age, gender identity, socioeconomic status, religion, spirituality, immigration status, education, and employment, among other variables" (American Psychological Association [APA], 2017).

Despite the stated importance of celebrating and promoting diversity, multicultural considerations in mental health services have been historically understudied (Huey et al., 2014, 2023). Mental health services researchers have proposed *conceptual* models outlining various aspects of diversity (e.g., ADDRESSING model, Hays, 2016; RESPECTFUL model; Ivey et al., 2011) and processes and procedures for incorporating multicultural considerations into psychotherapy (J. Chu et al., 2016; Hall et al., 2021; López et al., 2020; Sanchez et al., 2022). However, concrete guidelines for translating these conceptual models into clinical practice are lacking (Huey et al., 2023). A recent systematic review of 37 cultural competence trainings found that approximately two-thirds covered topics related to ethnicity and race, whereas fewer than one in five trainings covered topics related to religion, ability status, socioeconomic status, immigration status, and linguistic ability (W. Chu et al., 2022). Given the lack of adequate training on these topics, it is unsurprising that mental health service practitioners feel hesitant about broaching diversity-related topics with their clients (Bayne & Branco, 2018; Day-Vines et al., 2022; Jones & Welfare, 2017) – even though broaching benefits therapeutic alliance, client satisfaction with services, and practitioner multicultural competence (King, 2021; King & Borders, 2019). In the absence of more actionable practice guidelines for providing multiculturally competent[1] youth mental health care, longstanding disparities are likely to persist (Alegria et al., 2010; Hoffmann et al., 2022).

To provide multiculturally competent mental health care, practitioners and other client-interfacing staff must possess knowledge about various aspects of diversity and how those aspects of diversity influence client beliefs and behaviors, the therapeutic relationship, and treatment effectiveness (Huey et al., 2014; Sue et al., 1982, 1992). This knowledge has typically been assessed immediately after a multicultural competence training using a quantitative measure (W. Chu et al., 2022), making scores subject to recency effects and potential inflation as information is easier to retrieve through recognition than recall. Two qualitative studies, independent of any multicultural competence training, asked mental health staff to define "cultural sensitivity" and found themes related to awareness of cultural factors and consideration of cultural factors in assessment and treatment (Benuto et al., 2021; Zayas et al., 1996). Yet, which aspects of diversity (or cultural factors) are most commonly attended to by mental health staff? Also, although mental health staff may be able to articulate that aspects of diversity should be considered in assessment and treatment, can they articulate how (given the lack of existing practice guidelines)?

The current study explored how community mental health staff working with diverse youths and families conceptualize diversity and report integrating diversity considerations into their clinical practice. Better understanding community mental health staff's perspectives on diversity can elucidate potential strategies for increasing knowledge about various aspects of diversity, cultivating skills in applying that knowledge to case conceptualizations and treatment planning, and ultimately developing a multiculturally competent workforce.

Method

All study procedures were approved by the Institutional Review Board of the University of California, Los Angeles (IRB# 17–000627).

Participants

Community mental health staff were employed by one of the largest mental health and welfare agencies for youths and families in Southern California.

[1]Although several definitions of multicultural competence have been proposed, this paper uses "multicultural competence" to refer to knowledge of cultural beliefs, values, and behaviors and application of this knowledge in clinical practice. This is consistent with the definition provided by Betancourt et al. (2003), Huey et al. (2014, 2023), and Whaley and Davis (2007).

This agency provides a variety of services including outpatient and school-based mental health services, wraparound and in-home services, psychiatric services, psychological testing, and transitional housing and living assistance to more than 16,000 youths and families annually. Most youths and families served by this agency identify as low-income and as people of color.

Participating mental health staff ($N = 55$) included 21 clinicians, 9 clinical supervisors, 6 case managers, 5 community wellness specialists (i.e., bachelor's level staff who help clients develop coping and problem-solving skills), 4 directors or assistant directors, 4 referral managers (i.e., bachelor's or master's level staff who assist with managing and processing referrals), 3 parent partners (i.e., caregivers who have successfully navigated youth mental health services and who provide peer support to other caregivers on a similar journey), 1 EBT trainer, and 1 administrative executive.

Table 1. Participant background and demographics.

Background and demographics	*Mean* (*SD*)
Age	38.41 (9.54)
Years of clinical experience	5.48 (7.54)
Number of multicultural competence trainings attended	1.80 (1.11)
Background and demographics	**%**
Race/ethnicity	
Hispanic/Latine	44%
Non-Hispanic White	29%
Asian	13%
Black or African American	9%
Multiracial/ethnic	4%
Not reported	1%
Gender	
Female	89%
Male	9%
Not reported	2%
Born in another country	24%
Language (Monolingual English)	58%
Education	73%
High school diploma or GED	3%
Bachelor's degree	24%
Master's degree	73%
Specialty	
Marriage and family therapy	53%
Social work	25%
Another specialty (e.g., rehabilitation, child development)	11%
Not reported	11%
Theoretical orientation	
Cognitive behavioral	33%
Eclectic	24%
Family systems	15%
Psychodynamic	7%
Humanistic	5%
Not reported	16%
Licensed	29%

Note: Years of clinical experience was operationalized as the number of years that staff had been providing services in their current role, irrespective of their affiliation (e.g., the number of years that a clinician had been providing services as a clinician).

Additional information about participants' background and demographics is presented in Table 1.

Semi-structured interview

Community mental health staff were invited to participate in this study during monthly staff meetings in June and July 2017 (cf. Park et al., 2020 for additional information about the recruitment process). Semi-structured interviews with staff were conducted by four graduate students and one post-doctoral researcher between July and September 2017. Participants were provided with an overview of the study including any risks or benefits to participating, allowed to ask any questions about the study, and completed informed consent prior to participating in the semi-structured interview. As part of a comprehensive interview about community mental health staff's experiences working with diverse and historically underserved communities, participants were first asked the open-ended question, "What does diversity mean to you as a mental health professional?" Participants were then asked several questions about their work with diverse and underserved communities and prompted to consider diversity in terms of race, ethnicity, culture, sex, gender identity and expression, sexual orientation, socioeconomic status, religion, spirituality, disability, age, national origin, immigration status, language, and other identities. This study focuses on participants' responses to the opening interview question. Their responses to subsequent interview questions have been summarized elsewhere (Park et al., 2020; Torres Sanchez et al., 2022). Participants received a $10 gift card for completing the semi-structured interview. All participants responded to this opening question, and their responses were transcribed by members of the research team prior to coding.

Coding procedure

To understand how community mental health staff conceptualize diversity, our approach involved transforming qualitative data into quantitative values (Miles & Huberman, 1994; Palinkas et al., 2019). Recognizing that caution must be exercised when quantitizing qualitative data, this approach

allowed us to determine whether certain aspects of diversity were identified more frequently than others. This comparison would not be achieved with more traditional qualitative approaches, and a quantitative measure would evaluate participants' recognition (rather than recall) of various aspects of diversity. Given that community mental health staff must recall (rather than recognize) information about diversity when interacting with diverse clients, this method was intended to provide a representative glimpse into how community mental health staff conceptualize diversity.

Participant responses were quantified to describe conceptualizations of diversity and, particularly, to determine whether certain aspects of diversity are noted more frequently than others. An initial set of codes was derived from existing models of diversity and related constructs (e.g., intersectionality) (Crenshaw, 2013; Hays, 2016; Ivey et al., 2011). Next, the first and second authors independently reviewed interview transcripts and jointly revised the codes, code definitions, and numerical ratings to better capture participant responses. For example, an initial code related to intragroup differences was revised to reflect descriptions of sociocultural influences on beliefs and behaviors. Scoring for this code was also revised from presence/absence to a numerical rating ranging from 0 (limited understanding) to 3 (solid understanding), to reflect more nuanced differences in participants' understanding. The first and second authors then independently coded interview transcripts and met regularly to review and iteratively refine codes and code definitions. All interview transcripts were double-coded by the first and second authors. Any discrepancies were resolved through consensus.

Interview transcripts were coded for mentions of various aspects of diversity (e.g., race/ethnicity, gender identity, sexual orientation). Interrater reliability for aspects of diversity was calculated using Cohen's kappa, which is appropriate for two raters providing scores that are limited to two values (i.e., presence/absence of a particular aspect of diversity) (McHugh, 2012). Transcripts were also rated for the extent to which the participant described sociocultural influences on beliefs and behaviors, using a 4-point Likert scale ranging from 0 = demonstrated limited understanding of the effect of sociocultural influences on beliefs and behaviors (e.g., "people are different") to 3 = demonstrated solid understanding of the effect of sociocultural influences on beliefs and behaviors (e.g., mentioned microaggressions, discrimination, or privilege). Additionally, transcripts were rated for the extent to which the participant described incorporating sociocultural considerations into clinical practice, using a 4-point Likert scale ranging from 0 = described incorporating sociocultural considerations in problematic ways (e.g., promoted color-blindness) to 3 = described actively promoting social justice, equity, diversity, and inclusion. Interrater reliability for ratings of sociocultural influences on beliefs and behaviors and sociocultural considerations in clinical practice was calculated using intra-class correlation coefficients (ICCs), which is appropriate for ordinal data (Koo & Li, 2016). Interrater reliability statistics are presented in Table 2.

Results

Community mental health staff described an average of 3.30 ($SD = 1.89$) aspects of diversity.[2] Diversity was most frequently described in terms of culture[3] (76%) and ethnicity and/or race (64%). Religion (27%), sexual orientation (24%), and family structure (e.g., single parent or multigenerational households; 22%) were mentioned in approximately one-quarter of interviews. Other aspects of diversity – including socioeconomic status (18%), gender identity (15%), immigration status (15%), age (11%), and language (4%) – were mentioned infrequently (see Table 2).

Staff varied in the extent to which their descriptions mentioned sociocultural influences on clients' beliefs and behaviors, $M = 1.50$, $SD = .80$.

[2]There were no significant differences in staff's descriptions of aspects of diversity nor sociocultural influences on beliefs, behaviors, or clinical practice based on participant role (e.g., clinician), age, gender, race/ethnicity, language skills (e.g., monolingual), immigration status, education, specialty (e.g., social work), licensure status, years of experience, or number of multicultural competence trainings attended.

[3]Definitions of culture are often broad. For example, APA defines culture as "the distinctive customs, values, beliefs, knowledge, art, and language of a society or a community" (American Psychological Association, n.d.) For this study, we coded community mental health staff's responses as describing culture if they were consistent with the APA definition and did not reference a more specific group within society or a community.

Table 2. Descriptives and interrater reliability of codes.

Code	Frequency/ Mean (SD)	Interrater reliability	Example quote
Aspects of diversity			
Age	11%	κ = .78	"Diversity is understanding, you know, not only that race, religion, national origin but also *age* or any other of a millions of things that make people who they are … "
Culture	76%	κ = .92	"Diversity would mean different *cultures*, different backgrounds, different traditions … "
Family structure	22%	κ = .46	"It could be a single parent home, a two parent home, a multi-generational family home … "
Gender identity	15%	κ = .57	"Being open to working with different *gender identities* … "
Immigration status	15%	κ = .58	"It's very often people coming from different countries and having to adapt, integrate … "
Language	4%	κ = .85	"Just because two staff speak the same *language*, English or otherwise, it doesn't necessarily mean they are from the exact same background, that they have the same experiences … "
Mental health	11%	κ = .82	"Diversity in treating different mental illnesses and different presenting problems or diversity in trauma backgrounds … "
Neighborhood	9%	κ = .78	"Different cities have different types of environment so sending people that are familiar with that *neighborhood* to best meet [clients'] needs … "
Race/ethnicity	64%	κ = .71	"Families with like different cultural backgrounds than me, different cultural backgrounds from each other … two families might both be Hispanic, but they've experienced their lives in a very different way even though they are the same background … "
Religion	27%	κ = .96	"It's any factor that's going to impact how the family functions … their *religion* or their point of view … "
Sexual orientation	24%	κ = .71	"I think diversity can mean a lot of different things … diversity in *sexual orientation* … "
Socioeconomic status	18%	κ = 1.00	"Diversity means more to me than just racial, ethnic, or *socioeconomic* background … "
Other	25%	κ = .55	"It's different shapes, sizes … "
Sociocultural influences on beliefs and behaviors	1.50 (.80)	ICC = .80	See Table 3.
Sociocultural considerations in clinical practice	1.39 (.66)	ICC = .70	See Table 4.

Table 3. Participant descriptions of the influence of sociocultural factors on beliefs and behaviors.

Rating	Example quotes
0 = demonstrated limited understanding of the effect of sociocultural influences on beliefs and behaviors	" … differences in perspectives and experience." "It means differences and similarities." "Diversity really means just working with everyone and anyone that comes in for services."
3 = demonstrated solid understanding of the effect of sociocultural influences on beliefs and behaviors	"I recognize that with children and families there's a lot of cultural diversity … so it's broader than groups … and it's very individualized about each person and each family system. And especially those receiving services for mental health. I think that adds a different layer of diversity because I think there is a mental health culture and stigma that affects them at a level that's not often acknowledged." "I'm starting to learn as I keep working with families and different kinds of families that … there's some traditions that families have or ways families look at things that don't necessarily mean that their parenting skills are wrong or we need to kind of work with them on that. It's more of a preference, and this is the way they do it more as a family … I think [it's] good to start with questions of like, 'Well what makes you think that or where did you kind of learn that or why do you do that or what is that about?' So that I can understand more or even ask them about their culture if I need to know about it." " … it encompasses a lot of different groups of people and how subgroups of people identify themselves … let's say Black. [Staff] would think only African American but they wouldn't think African, they wouldn't think Cuban … and each one of these individuals, although we look alike, we have completely different cultures and how we interact with our families and how we look at mental health services."

Examples of low scoring and high scoring responses are presented in Table 3.

Staff also varied in the extent to which their descriptions mentioned incorporating sociocultural considerations into their clinical practice, $M = 1.39$, $SD = .66$. Examples of low scoring and high scoring responses are presented in Table 4. Notably, no responses were perceived by coders as problematic; rather, ratings were more reflective of relatively brief or vague responses (e.g., " … a variety of ages, backgrounds, cultures, ethnicities, races. There's a lot of different types of diversity.").

There were no significant differences in the number of aspects of diversity mentioned, extent to which participants described sociocultural influences on client beliefs and behaviors, or extent to which participants described incorporating sociocultural considerations into their clinical practice by staff role (e.g., clinician) or highest degree (e.g., Master's degree). A Pearson's correlation showed a moderate, positive association between years of

Table 4. Participant descriptions of incorporating sociocultural considerations into clinical practice.

Rating	Example quotes
1 = acknowledged how sociocultural considerations could influence clinical practice without providing specific or concrete details	"When I think of diversity of the consumers that are served in the mental health field, I think of consumers coming from a variety of backgrounds." "I guess it's just working with everybody, all different kind of families." "It's just the differences and the tolerance we have for them."
3 = described actively promoting social justice, equity, diversity, and inclusion	"As a mental health professional, I think it is incredibly important to be sensitive to these various issues to know how to explore them in a way with families that is respectful and empowering and does not contribute to marginalization … " "In my role as the administrator, my purpose is to make sure that all diverse populations that live in this community get their mental health needs met in a way that is respectful … my role is to make sure that my staff clearly understand what diversity means. It's my responsibility to make sure they have the necessary training that they need in order to go out in this very diverse community and provide mental health services." " … in working with families in public mental health, I think that the more interesting impact is like, 'Well how does all these differences, where do they come from and… how do they impact families in good or negative ways or maybe neutral ways, but in ways that, you know, I am able to understand them better or work in services with us better?'"

Note: Responses were rated using a 4-point Likert scale ranging from 0 to 3; however, no responses were rated as 0 (described incorporating sociocultural considerations in problematic ways).

clinical experience and the extent to which the participant described incorporating sociocultural influences on client beliefs and behaviors, $r = .42$, $p = .003$. There were no significant associations between years of clinical experience and the number of aspects of diversity mentioned nor the extent to which participants described incorporating sociocultural considerations into their clinical practice.

Discussion

This study investigated community mental health staff's perspectives on diversity. Specifically, this study sought to characterize how staff described various aspects of diversity, the extent to which they described sociocultural influences on beliefs and behaviors, and the extent to which they described incorporating sociocultural considerations into their clinical practice.

Results indicated that community mental health staff perceived the concept of diversity to be multidimensional. Diversity was most often described in terms of *culture*, which includes sociocultural influences on values, beliefs, and behaviors. Given differences between and within social groups, recognition and understanding of how social processes, institutions, and structures influence a client's lived experience may be helpful in developing appropriate case conceptualizations and treatment plans. For example, an adolescent who experiences pervasive microaggressions may benefit from trauma-informed mental health care, even though they might not meet DSM-5-TR criteria for a trauma-related disorder (Saleem et al., 2020; Williams et al., 2018).

Diversity was also frequently described in terms of *ethnicity* and *race*. This conceptualization is consistent with many recent calls and commitments to promote diversity (APA, 2021, 2022; National Institute of Mental Health, n.d.) and represents an important area of focus within the field, given well-documented ethnic-racial mental health disparities (Alegria et al., 2010). At the same time, disparities in youth mental health care access, quality, and outcomes exist across social groups (Hoffmann et al., 2022). Provision of multiculturally competent youth mental health care must consider sociocultural influences on mental health and mental health treatment for various minoritized groups. For example, sexual minoritized youths have more than three times increased odds of attempting suicide than their heterosexual peers (Hoffmann et al., 2022); however, fewer than one-quarter of staff from this study described diversity in terms of sexual orientation.

Results also showed that community mental health staff varied in the extent to which they described sociocultural influences on beliefs and behaviors, with many staff offering vague comments. Staff with more years of clinical experience offered more detailed descriptions of sociocultural influences on beliefs and behaviors, but staff descriptions did not differ by staff role nor level of education. These results are intriguing given that staff with more advanced degrees likely receive more multicultural competence training; however, clinicians who receive multicultural competence training do not necessarily possess

enhanced multicultural knowledge and skills (Benuto et al., 2018; Huey et al., 2023), and there is much room for improvement in the multicultural competence training offered by graduate programs (Galán et al., 2024; Metzger et al., 2023). It is possible that experience working with diverse youth and families provides more active learning opportunities than multicultural competence trainings provided by graduate programs and that these active learning opportunities cultivate deeper conceptualizations of diversity. It is also possible that these responses were a function of the larger semi-structured interview, as subsequent interview questions were usually prioritized. It is also possible that these responses reflect uncertainty around how sociocultural factors may influence beliefs and behaviors, particularly for less experienced staff, as this is a relatively understudied area of clinical child and adolescent psychology (Sanchez et al., 2022). Additionally, although the number of studies on this topic has increased over the past decade, the translation of this clinical research to clinical practice has been slow to nonexistent. Accordingly, information on sociocultural influences on beliefs and behaviors is often absent in multicultural competence trainings (Huey et al., 2023) and subsequently in staff's multicultural knowledge (Galán et al., 2021). In other words, mental health staff may comprehend that social and cultural contexts influence their client's mental health but may not receive adequate training to conceptualize how specific cultural beliefs, values, and behaviors (e.g., values of familismo, machismo, and marianismo in Latine families) influence their client's perceptions of their mental health concern and response to treatment.

Relatedly, results showed that most community mental health staff described incorporating limited sociocultural considerations into their clinical practice, albeit there was a wide range in staff's responses. Again, it is possible that staff incorporate more sociocultural considerations into their clinical practice than they described in this first interview question. It is also possible that limitations of the current evidence base make it difficult to develop clear practice guidelines on how to deliver culturally responsive youth mental health care (Park et al., 2023) and that interview responses reflected this uncertainty. That is, mental health staff may aspire to assess for social and cultural influences on their client's mental health and provide mental health care that is compatible with their client's cultural beliefs, values, and behaviors – but mental health staff may lack the training and professional resources to translate these aspirations into actions.

Findings from this study highlight several potential directions for developing a multiculturally competent workforce. First, efforts for promoting mental health staff's multicultural knowledge should include information about contextual factors and intersectionality among and between multiple social groups, particularly groups that staff are likely to encounter in their clinical practice. Second, these multicultural competency efforts should include information about sociocultural influences on beliefs and behaviors. This information is directly relevant to case conceptualization and treatment planning and can help mental health staff provide care that is culturally compatible with youths and families' values, beliefs, and behaviors (Sanchez et al., 2022). Third, more empirical research is needed to identify for whom, when, and how mental health treatments should be culturally adapted to optimize outcomes for youths and families (Lau, 2006). This research could help inform practice guidelines for providing multiculturally competent youth mental health care and increase staff's self-efficacy in incorporating sociocultural considerations into their clinical practice.

Findings from this study should be interpreted in the context of some limitations. One limitation is that community mental health staff were asked about diversity as part of a comprehensive interview on their experiences working with historically underserved communities, and results reflect responses to a single question from that interview. It is possible that some staff may have provided a brief response to this interview question and elaborated about diversity in subsequent interview questions. However, other studies using these data have similarly found that staff tended to focus on race and ethnicity and to offer little concrete guidance on how to incorporate multicultural considerations into clinical practice (Park et al., 2020). A second limitation is that study data were collected in 2017. Given increasing calls and commitments to promoting diversity (National Institute of Mental Health, n.d.), particularly since 2020, it is possible that these results may reflect an

underrepresentation of current multicultural knowledge. Another limitation is that all community mental health staff were recruited from a single agency in Southern California. Although this agency serves diverse youths and families across more than 3,500 square miles spanning rural, suburban, and urban areas, it is possible that staff's responses may reflect social groups that are prominent in Southern California and that staff in other locales may have different perspectives on diversity.

Conclusion

Likely as a result of graduate training, continuing education, and/or lived experiences, community mental health staff appear to have foundational multicultural knowledge. Yet, limited existing guidance on how to apply this multicultural knowledge in clinical practice may pose challenges to providing multiculturally competent mental health care to youths and families, particularly those from groups that have not been an explicit focus of diversity efforts. Although the field of clinical child and adolescent psychology has made undeniable progress in promoting diversity, enhancing mental health staff's knowledge of the diverse social groups in the United States as well as the social basis of cultural values, beliefs, and behaviors is foundational for promoting multiculturally competent mental health care to all youths and families in need.

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