Poverty and Mental Health: How Do Low-Income Adults and Children Fare in Psychotherapy?

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Poverty is associated with an increased risk for psychological problems. Even with this increased risk for mental health problems and need for care, many low-income adults and families do not receive treatment because of logistical, attitudinal, and systemic barriers. Despite significant barriers to obtaining care, research suggests that low-income individuals show significant benefit from evidence-based mental healthcare. In this article, we review the link between poverty and mental health, common barriers to obtaining mental health services, and treatment studies that have been conducted with low-income groups. Finally, we discuss the implications of the research reviewed and offer recommendations for clinicians working with low-income children or adults, highlighting the importance of evidence-based care, extensive outreach, and empathic respect. J. Clin. Psychol: In Session 69:115–126, 2013.

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Poverty is consistently linked with mental health problems. Despite the need for care, many poor children and adults do not receive mental health services. However, research suggests that when low-income individuals do receive evidence-based mental healthcare, they respond well to treatment. First, we summarize the link between poverty and mental health and then discuss the various barriers to obtaining mental health services. We next review treatment studies that have been conducted with low-income groups and provide recommendations for clinicians working with low-income children or adults.

Poverty and Mental Health

In the United States, 46.2 million people (15.1%) are living below the federal poverty line, a number that has increased steadily since 2007 (DeNavas-Walt, Proctor, & Smith, 2011). Further, the percentage of American children living in poverty has increased to 22% (DeNavas-Walt et al., 2011). The rates of poverty are higher among ethnic minority adults and families, with 27.4% of African Americans, 26.6% of Hispanic/Latinos, 27.0% of American Indian/Alaska Natives, and 12.1% of Asians living in poverty compared with 9.9% of non-Hispanic Whites (DeNavas-Walt et al., 2011; Snipp, 2005). With current economic conditions in the United States, many more adults and children face economic hardship as poverty levels rise. These numbers are troubling because poverty is associated with poor health and well-being for children and adults alike.

Poverty is consistently linked to poor psychological outcomes. Research suggests that living with poverty-related stress increases risk for psychological disorders (e.g., Lipman & Boyle,

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2008), while severe mental illness also increases the likelihood of experiencing poverty (Breslau, Lane, Sampson, & Kessler, 2008). Social causation theory suggests that poor individuals develop psychological and physical health problems as a result of living with poverty-related hardship (e.g., Wadsworth & Achenbach, 2005). For example, poverty precedes the development of mental health problems, such as depression and anxiety (Hudson, 2005). Low socioeconomic status (SES), an individual's or family's economic and social position in relation to others, based on income, education, and occupation, also affects children and adolescents. For example, family SES predicts anxiety at 15 years of age (Miech, Caspi, Moffitt, Wright, & Silva, 1999). Furthermore, increases in income, or emergence out of poverty, have been linked to declines in psychological problems such as aggression (Costello, Compton, Keeler, & Angold, 2003). In the other direction, early onset mental disorders diminish educational attainment (Breslau et al., 2008) and mental illness in the previous 12 months predicts decreases in earnings controlling for other sociodemographic variables (Kessler et al., 2008). Given this bidirectionality of risk, high-quality mental health services are needed for low-income adults and children.

Much of the risk for mental health problems can be linked to higher levels of stress among individuals and families living in poverty. Several well-researched stress models (e.g., Conger et al., 2002) describe the stress processes by which economic hardship negatively affects health and well-being within a family. Poor individuals and families experience more chronic and uncontrollable life events and stressors than the general population (e.g., Ennis, Hobfoll, & Schröder, 2000) and these day-to-day stressors are related to poor psychological health. Poverty creates a context of stress in which stressors build on one another and contribute to further stress. Common stressors faced by low-income individuals and families include economic strain, conflict among family members, exposure to violence, frequent moves and transitions, and exposure to discrimination and other traumatic experiences (Wadsworth et al., 2008). Such poverty-related stress is associated with symptoms of depression, anxiety, hostility, and aggression among poor families (Hammack, Robinson, Crawford, & Li, 2004; Wadsworth et al., 2008).

In particular, poverty is a strong risk factor for exposure to trauma and violence, which increases risk for posttraumatic stress disorder (PTSD), anxiety, and depression (Cunradi et al., 2002). In fact, 20%-50% of American children have been exposed to violence in their homes, schools, and communities (Finkelhor & Dziuba-Leatherman, 1994), and poor and ethnic minority individuals are at highest risk for exposure to violence (Perkins, 1997). In addition to increasing risk for internalizing problems (i.e., PTSD, anxiety, and depression), exposure to trauma also contributes to aggression and delinquency, alcohol use, tobacco use, drug problems, and academic problems (e.g., Kearny, Wechsler, Kaur, & Lemos-Miller, 2010).

In addition to pervasive community violence, low-income adults and children are more likely to live in neighborhoods with less resources and higher rates of poverty (Attar et al., 1994). Community-level stressors such as high-poverty rates, high-unemployment rates, low levels of education, and high-residential mobility in the community are chronic and affect all members of a given community. Attar et al. (1994) described these contextual stressors as "neighborhood disadvantage," which was measured using a variety of indicators including percentage of families receiving public aid, income levels, and housing. Children from more affluent neighborhoods with more community resources are less likely to engage in juvenile delinquency (Brooks-Gunn, Duncan, & Aber, 1997), while residential mobility and neighborhood poverty predict poorer functioning among low-income adults and children in terms of both internalizing and externalizing problems (Santiago, Wadsworth, & Stump, 2011). Neighborhood disadvantage adds to the accumulation of stress, increasing risk for psychological problems.

Given the multitude of stressors that low-income individuals face, they are at increased risk for mental health disorders. Further, mental illness can interfere with educational and occupational attainment, increasing risk for poverty. High-quality and evidence-based interventions are needed to successfully reduce mental health problems and promote healthy functioning. Though mental healthcare is needed, low-income individuals and families often have reduced access to high-quality services.

Access to Mental Healthcare

Utilization of Mental Health Services

Many low-income adults and children do not receive mental healthcare despite need. Among children in need of mental healthcare, 75%-80% do not get that care (Kataoka, Zhang, & Wells, 2002). Factors associated with lower SES often exacerbate these statistics. For example, uninsured children have even more unmet mental healthcare needs, with an estimated 87% of uninsured children not receiving needed care (Kataoka et al., 2002). In one study with low-income adults with a high likelihood of exposure to trauma, 22% met criteria for PTSD, but only 13% of those with PTSD had received trauma-related treatment (Davis, Ressler, Schwartz, Stephens, & Bradley, 2009). Other factors such as single-parent status, neighborhood disadvantage, and social isolation are linked to less service utilization (Snell-Johns, Mendez, & Smith, 2004). Single-parent families are more likely to drop out of treatment prematurely and have worse treatment outcomes (Kazdin & Mazurick, 1994). Families residing in low-income neighborhoods are also less likely to receive services and are more likely to drop out (McKay, Quintana, Kim, Gonzales, & Adil, 1999).

Ethnic minority adults and children are also identified as having lower rates of use of mental health services and are disproportionately poor (Fass & Cauthen, 2008). Studies have identified both Latino and/or African American children as less likely to receive needed care compared to White children. In a national study, Latino children had the highest level of unmet need, with 88% of Latino children in need of mental healthcare, not receiving that care (Kataoka et al., 2002). Research on utilization among ethnic minority adults mirrors that of children. Data from the National Comorbidity Survey suggested that Latinos and African Americans were less likely to access specialty mental health care than Whites (Alegría et al., 2002). In a study of postpartum mental health care, Latinas and African American women were less likely to initiate treatment, receive follow-up treatment, or continue care than their White counterparts (Kozhimannil, Trinacty, Busch, Huskamp, & Adams, 2011). Some evidence suggests that immigrants may have particularly low utilization of mental health services (Hochhausen, Le, & Perry, 2011). These troubling disparities in utilization can be linked to a number of logistical, attitudinal, and systems-level barriers.

Logistical Barriers

Barriers associated with the stress of poverty often prevent utilization of services and are predictive of poor engagement and retention in mental health services (Snell-Johns et al., 2004). Cost and lack of insurance are certainly significant barriers to mental health service utilization among low-income groups (e.g., Snowden & Thomas, 2000). Low-income adults report having to juggle many competing obligations, which may limit their ability to prioritize mental health treatment over more immediate concerns (Hines-Martin, Malone, Kim, & Brown-Piper, 2003). Transportation, finances, and childcare are also frequently cited barriers (e.g., Davis et al., 2009). For example, low-income adults often have to travel longer distances for care. Further, some low-income individuals may be unaware of how to obtain treatment or believe that they are ineligible for services (Davis et al., 2009). Weekly visits may be difficult for low-income adults with shift work schedules or those that must rely on public transportation (Krupnick & Melnikoff, 2012). However, some research suggests that offering transportation, childcare, and low-cost services will reduce barriers to access and increase service providers' ability to reach underserved families (e.g., Taylor & Biglan, 1998). Thus, addressing logistical barriers is key when intervening with low-income adults and families.

Barriers Related to Perceptions About Care

In addition to logistical barriers such as cost, competing priorities, and transportation, researchers have identified attitudinal barriers to engaging low-income families in services. For example, stigma-related concerns reduce the desire for mental health treatment among immigrant African and Latina women, which may contribute to underutilization of mental health

services (Nadeem et al., 2007). More generally, low-income and ethnic minority individuals may be hesitant to seek care in traditional settings because of mistrust stemming from historical persecution and racism. Latino and African American individuals frequently report being treated poorly or misjudged because of their race or ethnic background (LaVeist, Diala, & Jarrete, 2000). In addition to general fear and distrust, some groups of low-income adults report specific fears that prevent service utilization such as the fear of losing custody of their children (Copeland & Snyder, 2011). Immigrants report concerns about their immigration status, resulting in a reluctance to access care (Kaltman, Hurtado de Mendoza, Gonzales, & Serrano, in press). Further, family or community disapproval and negative therapy experiences of others have also been reported as barriers among low-income African American women (Davis et al., 2009), which may result in more comfort accessing help through informal sources rather than formal service utilization. Finally, some groups endorse attitudes such as self-reliance and beliefs that the illness will get better on its own, both of which likely influence treatment-seeking decisions (Steele, Dewa, & Lee, 2007).

Systems-Level Barriers

Beyond barriers that can be attributed to obstacles faced by or beliefs-held by individuals, systems-level barriers contribute to disparities in access to appropriate mental health services (Miranda, Lawson, & Escobar, 2002). For example, there are inadequate numbers of bilingual and ethnic minority providers and a lack of culturally congruent services (McCabe, 2002). In some cases, therapists' beliefs, biases, and a lack of cultural competence negatively affect treatment and utilization (Borowsky et al., 2000). Primary care providers or support staff that are responsible for initial screening and referrals for services report a lack of formal training and support for dealing with issues common among low-income patients, such as trauma (Green et al., 2011). Providers that feel unprepared to deal with such issues may be less effective in assessment and engagement into care. Further, primary care providers may be unaware of what low-cost mental health resources are available, contributing further to underutilization (Green et al., 2011). Even in mental health clinics, there may be limited agency or systemic support for intensive outreach. In addition to lack of training and support, some clinicians may be quick to label clients as "resistant" or not committed to care after limited outreach (McKay et al., 2011). When low-income adults and families are successfully engaged in services, are the evidence-based treatments we have effective? We explore this question in the next section.

Treatment Outcomes Among Low-income Adults and Children

Low-income adults and children are at increased risk for mental health problems, but are less likely to receive needed care. Questions have been raised about the effectiveness of evidence-based treatments for low-income and ethnic minority populations because such treatments are often researched in university settings with predominately Caucasian and middle to high-income individuals and families (Department of Health and Human Services, 2001; Miranda et al., 2003). However, numerous studies have examined evidence-based treatments with low-income individuals and families, finding that when they do receive quality care, outcomes are positive. Examples of intervention studies conducted with low-income samples are discussed below.

Intervention Studies with Low-Income Adults

In a study conducted by Miranda et al. (2002), low-income and ethnic minority women were screened though county entitlement programs for depression and then randomized to receive medication, cognitive-behavioral therapy (CBT), or a community referral. Medication and CBT outperformed the community referral, with only 15 women attending a community referral session out of 89 (Miranda et al., 2002). A long-term follow-up of this study found clinically significant decreases in depression for both medication and CBT at a 1-year follow-up (Miranda et al., 2009). Seventy-six percent of women assigned to medications received 9 or more weeks of guideline-concordant doses of medications, while 36% assigned to psychotherapy received six or

more CBT sessions. Results showed that both medication and CBT were superior to community referral in lowering depressive symptoms 1 year posttreatment. At this 1-year follow-up, 50.9% assigned to antidepressants, 56.9% assigned to CBT, and 37.1% assigned to community referral were no longer clinically depressed. These findings suggest that both antidepressant medications and CBT are effective in treating depression among low-income and ethnic minority women and outperform typical community care (Miranda et al., 2009).

Additional research has compared the effectiveness of evidence-based care across income levels (Roy-Byrne et al., 2011). Primary care patients with panic disorder who were participating in a randomized controlled trial comparing CBT, pharmacotherapy, and usual care were divided into those patients above and below the poverty line. Participants below the poverty line showed more symptom severity and comborbidity at baseline. However, results suggested that reductions in clinical symptoms in response to evidence-based care were comparable across the two groups (Roy-Byrne et al., 2011). Thus, standard CBT and pharmacotherapy treatments for panic disorder were just as effective among poor individuals as compared with higher income individuals. However, because of greater severity of illness among poor individuals, treatment programs may need to be extended to treat residual symptoms and achieve greater remission of symptoms.

Another study examined the efficacy of interpersonal psychotherapy (IPT) for low-income women with chronic PTSD (Krupnick et al., 2002). Nontreatment-seeking, predominantly minority women were recruited in family planning and gynecology clinics. Individuals with interpersonal trauma histories (e.g., assault, abuse, and molestation) who met criteria for current PTSD were randomly assigned to treatment or a waitlist control group. Participants in the IPT group evidenced significantly greater reductions in PTSD and depression symptom severity as well as greater improvements in interpersonal functioning as compared to those in the waitlist control group (Krupnick et al., 2002).

Other researchers have also examined the effects of IPT with low-income groups and found positive results. Grote et al. (2000) examined IPT among low-income women with prenatal depression. In this study, a culturally relevant version of IPT was compared to usual care. Women who received IPT showed greater reductions in depression and improvements in social functioning compared to the usual care group (Grote et al., 2000). Further the IPT group showed greater treatment engagement and retention.

Additional studies have found that collaborative care for the treatment of depression among low-income individuals with comorbid medical conditions is also effective. Among low-income Latino adults with cancer, those that received a care manager, problem-solving intervention, medication, symptom monitoring, and relapse prevention showed greater reductions in symptoms of depression relative to enhanced usual care (Ell, Xie et al., 1994). Similarly, a socioculturally tailored collaborative care intervention for depression among low-income Latino individuals with diabetes was associated with greater depression improvement relative to control (Ell, Katon et al., 2004).

One randomized controlled trial (RCT) compared a CBT educational course designed to prevent depression to a control condition—either information only or no intervention (Muñoz et al., 2011). Low-income minority adults who received the CBT course had fewer symptoms of depression than the control group at posttreatment and 1-year follow-up (Muñoz et al., 2011). Thus, CBT approaches can be effective for prevention of depression. Taken together, a growing body of research suggests that when evidence-based treatments are delivered, they are effective among low-income adults.

Intervention Studies with Low-Income Children and Families

Research has also found that when low-income children and adolescents can access evidence-based care, they also benefit from this treatment. For example, the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a brief, 10-session group school-based program, has improved PTSD and depressive symptoms among poor Latino elementary and middle school students exposed to community violence (Kataoka et al., 2008; Stein et al., 2011). The intervention incorporates education about reactions to trauma, relaxation training,

cognitive therapy, stress or trauma exposure, and social problem solving (Jaycox, 1997). Preliminary findings also suggest that this program may have effects on school performance (Kataoka et al., 1998a). Additional research focused on engaging and intervening with parents of children enrolled in CBITS has demonstrated improvement in parental coping and functioning as a result of a brief skills-based parental component (Santiago, Kataoka, Cordova, Alvarado-Goldberg, & Escudero, 2012).

Multisystemic therapy (MST) is another treatment that has been found to be effective in reducing re-arrest rates, time incarcerated, and self-reported offenses among low-income adolescents (e.g., Henggeler, Clingempeel, Brondino, & Pickrel, 2008). Intervening with multiple systems, MST individualizes the treatment with the family, peers, and school by taking into account the sociocultural context of each youth and family (Henggeler et al., 1992). Studies of MST have demonstrated its positive effect on family correlates of antisocial behavior as well as adjustment in family members.

One quality improvement study for adolescent depression in primary care, Youth Partners in Care (YPIC), found improvement in treatment uptake, depressive symptoms, and functioning relative to usual care (Asarnow et al., 2002). The study included screening, supervised treatments, and education and support for primary care clinicians. Results highlighted that adolescents can not only access screening and treatment through primary care, but that access can improve mental health outcomes when primary care clinicians are supported and trained (Asarnow et al., 2002). Further, a follow-up to this study examined intervention effects within racial/ethnic groups (Ngo et al., 2001). African American youths in the intervention group experienced significant reductions in depression symptoms and had higher rates of use of specialty mental health care at the 6-month follow-up. Among Latino youths, the intervention was associated with significantly greater satisfaction with care. Intervention effects were weak among White youths. Thus, quality improvement interventions may help to reduce disparities in mental health care for youth from racial/ethnic minority groups.

Low-income children are also largely represented in the child welfare system and are at extremely high risk for mental health disorders and long-term functional impairment across multiple domains (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). A promising approach within the child welfare system is Multidimensional Treatment Foster Care (MTFC; Chamberlain, 1998a). Treatment Foster Care programs were first designed to target delinquency and aimed to integrate service delivery systems to include foster parents as members of the treatment team, who also receive specialized training and support (Chamberlain & Reid, 1998b).

MTFC is a three-tiered approach that includes system level supports, family and individual treatment, and school interventions (Chamberlain & Reid, 1998b). Foster parents receive substantial training in behavior management, along with individual therapy for the child, family therapy with foster and/or biological families, and coordination with school interventions. When compared with outcomes for adolescents living in group homes, those who received MTFC engaged in less criminal activity and were more likely to return to live with biological relatives (Chamberlain & Reid, 1998b). Treatment Foster Care has also been investigated with preschool children experiencing their first out-of-home placement—Early Intervention Foster Care (EIFC)—and was found to lead to better behavioral adjustment compared with children who did not participate in the program (Fisher, Gunnar, Chamberlain, & Reid, 2000). A less intensive version of Treatment Foster Care, applied as a universal intervention, improved parenting skills, which reduced child behavior problems (Chamberlain et al., 2005). These multilevel interventions are promising in their ability to improve functioning and mental health in a particularly high-risk group of low-income children.

Though the focus of this article is on psychotherapy, prevention programs have a long history of being implemented in community settings that serve low-income children and families. Many effective prevention programs incorporate skill building to manage chronic and transitional stressors that many low-income children experience. For example, the Improving Social Awareness – Social Problem-Solving (ISA-SPS) Program led to improvements in coping with stressors related to middle school transition along with significant reductions in problem behavior over 6 years (Bruene-Butler, Hampson, Elias, Clabby, & Schuyler, 1997). The Promoting Alternative

THinking Strategies (PATHS) Program is another program that has demonstrated improvement in emotion regulation and problem-solving skills and reductions of internalizing and externalizing problems (e.g., Greenberg & Kusché, 1998). Other effective prevention programs that target skill building include the Anger Coping Program**,** which comprises 18 sessions that teach affect identification, self-control, and problem-solving skills (Lochman, 1985). The Anger Coping Program has grown into the Coping Power Program, which has demonstrated positive effects on delinquent and aggressive behavior as well as substance use (Lochman & Wells, 2003).

Further, some programs designed as treatment have now been applied in a prevention framework. For example, prevention programs targeting parents have been adapted from the Parent and Children Training Series (Webster-Stratton, 1992a; Webster-Stratton, 1992b), now referred to as The Incredible Years: Parents, Teachers, and Children Series, and the Helping the Noncompliant Child curriculum (Forehand & McMahon, 1981). Preventive interventions for older children and youth, such as Signs of Suicide, significantly reduced rates of suicide attempts and increased knowledge and adaptive attitudes about depression and suicide among high school students (Aseltine & DeMartino, 2004). Overall, prevention and intervention research with low-income children and families suggests significant benefit.

Implications and Conclusions

Low-income adults and children are at increased risk for mental health problems. Numerous stressors common in the lives of low-income individuals, such as economic strain, neighborhood disadvantage, exposure to violence, disrupted family functioning, and discrimination contribute to this risk, though it is likely the accumulation of stress that is particularly damaging. Thus, it is important that low-income individuals and families have access to high-quality, evidence-based mental health services in order to reduce mental health problems.

However, low-income individuals and families also face numerous logistical, attitudinal, and systemic barriers to obtaining mental health services that cannot be ignored when implementing evidence-based interventions. Transportation, childcare, lack of health insurance, and difficult work hours impede the ability to get needed care. Further, fear, distrust, and stigma-related concerns may also dissuade individuals from seeking care. Thus, we must ensure that efforts are made to decrease logistical and engagement barriers in mental health services.

Overall evidence-based treatments have demonstrated effectiveness among low-income adults and children. However, the studies summarized above employed engagement and retention strategies that must be considered when treating low-income populations. Many of the interventions tested implemented intensive outreach, provided childcare and transportation, and offered food and flexible scheduling to meet the needs of low-income adults (e.g., Krupnick et al., 2002). Finding convenient locations to provide care (churches, head start programs, primary care clinics) is essential for providing care to low-income individuals (Miranda et al., 2009). Further, although culturally sensitive adaptations alone are unlikely to improve outcomes, they may be important for engaging low-income adults and families into care (Miranda et al., 2009).

Recommendations for Clinicians

For clinicians working with low-income individuals and families, there are a number of important recommendations that have emerged from the growing body of research regarding interventions with these groups. First, evidence-based treatments have been effective when tested with low-income samples. Therefore, using treatment approaches with a solid evidence base, when available, will help to ensure that low-income adults and children receive high-quality care. Though evidence-based care is clearly important, when working with low-income individuals, some flexibility and tailoring within the approach is also needed.

Flexibility in providing evidence-based care includes understanding the high degree of stress that low-income families experience and allowing for treatment schedules that may vary from the typical one session per week for 12–16 weeks. Along with empathic understanding, a high degree of outreach is needed for initial engagement in treatment and for retention. Some low-income individuals may not be familiar with mental health services and thus be reluctant to prioritize

treatment over more immediate concerns. However, research suggests that when clinicians and all program support staff are trained to be aware of these barriers among low-income individuals and families in addition to utilizing strategies for overcoming such barriers, engagement in services improves (Korfmacher et al., 1998b; McKay et al., 2011). Significant reductions in the no-show rate for first appointments have been found when clinicians employ strategies such as telephone engagement that aims to restructure logistical barriers, explore parental concerns and beliefs about coming to treatment, and highlight parental strengths (McKay, McCadam, & Gonzales, 1996). In one study, low-income women were contacted an average of approximately nine times before entering medication care and ten times before beginning psychotherapy (Miranda et al., 2002). However, this intensive outreach resulted in engagement in services and, ultimately, improved outcomes.

Further, in this same study, low-income women who were reluctant to begin medication or psychotherapy were offered an educational session before agreeing to care (Miranda et al., 2002). The majority of participants attended the educational meeting, suggesting that providing more information and education about services is key for engagement. Thus, clinicians working with low-income adults and children can increase engagement and participation in services by utilizing intensive engagement strategies such as additional education as well as continued and frequent contact.

Along with intensive outreach, maintaining a position of understanding and respect is essential for building trust and providing care. Low-income and ethnic minority individuals may be understandably distrustful of traditional care because of historical persecution and racism. Further, low-income parents may have had negative experiences in finding care for their child or may feel blamed for their child's difficulties. In our experiences, extensive outreach and attempts to build trust by phone prior to visits has increased acceptance of services. Communicating a willingness to meet with individuals where they are ultimately appears to increase services utilization—whether that means an educational meeting before agreeing to care, a specific time or location that is convenient to the patient, or multiple phone calls to convey consistent outreach.

In addition to communicating respect and building trust, cultural sensitivity can also improve engagement into treatment. Although cultural adaptations may not improve the effectiveness of evidence-based treatments, they may be important for engagement and retention in such treatments. With interventions that include applying skills to hypothetical situations, it is important for those situations to be tailored to match experiences common among low-income and ethnic minority individuals (Krupnick et al., 2002). By being aware of cultural factors, clinicians can tailor the presentation of material in a way that is more acceptable given certain beliefs or values. For example, clinicians working with immigrant families need to have an awareness of issues related to immigration trauma and acculturation stressors that immigrant families commonly face and have competence in assessment for and treatment of those issues (Pumariega, Rothe, & Pumariega, 2005).

Immigrant families also appear to benefit from relational engagement, thus working towards a collaborative relationship may increase retention in services (Suarez-Orozco, Rhodes, & Milburn, 2009). Engagement and retention in care may be improved when clinicians are open to exploring potential doubts or ambivalence about receiving care that may stem from an individual's cultural background. Finally, clinicians can look for opportunities to build on strengths that may come from one's culture. When these efforts were implemented with low-income Latino immigrant parents, parent engagement in their child's treatment increased dramatically, parents reported increases in coping and parenting skills, and reported high satisfaction (Santiago et al., 2012).

Conclusion

Many low-income children and adults are at greater risk for mental disorders and are in need of high-quality care. Despite this need, access to mental healthcare within low-income communities is often limited and logistical, attitudinal, and systems-level barriers may contribute to underutilization of care. However when low-income individuals and families are engaged in evidence-based care, their outcomes are generally positive. Thus, the field must make progress

in disseminating effective treatments to community settings that reach underserved populations. As part of this effort, clinicians and service providers should provide evidence-based treatments with flexibility and sensitivity for the high degrees of stress often faced by low-income individuals and families. Intensive outreach is needed to gain initial trust and engagement in services.

Further, continued outreach and cultural sensitivity can contribute to retention in services. In addition to individual clinicians receiving support and training to employ such strategies, larger systems of care can formalize such efforts for broader outreach. For example, the Montgomery Cares Behavioral Health Program (MCBHP) adapted and implemented a collaborative care intervention serving the local low-income and uninsured population, many of whom were immigrants (Kaltman, Pauk, & Alter, 1997). Adaptations included a family support worker to assist with basic needs and accessing social services (referrals for food, housing, clothing, etc.), bilingual staff members, and expanding diagnosis and treatment targets to include PTSD due to high rates of trauma. These adaptations resulted in a substantial increase in the number of low-income adults and families that accessed and received care through MCBHP (Kaltman et al., 1997). Such efforts on the part of service providers and larger systems of care have the potential to contribute to improving the mental health of low-income children and adults that might otherwise interfere with success in interpersonal, educational, and occupational realms.

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