Chapter Ten

Children of Color in Systems of Care

An Imperative for Cultural Competence

Larke Nahme Huang
Girlyn F. Arganza

In previous chapters, we focused primarily on the individual child, grounding our approach in three frameworks: a developmental, an ecological, and a minority mental health perspective. Through the integration of these perspectives, we have attempted to craft a comprehensive picture of the ecology of the child, the child's cultural background and history, and the culturally determined developmental challenges and mental health issues confronting these children of color. This has been blended with a discussion of culturally appropriate strategies for mental health interventions for these youth, providing guidance for clinical practice. Although this represents a solid beginning for clinical practice and intervention, it is only a beginning and only part of the picture.

An ecological approach examines the context of the practitioner, as well as that of the client, in this case, the child or family. Similar to the child, the practitioner is embedded in a nested array of programs, policies, and systems that have an impact on the clinical work with the child and family. The practitioner is often part of a system with its own culture, values, rules, regulations, and eligibility requirements—all of which enter into the formulation of an intervention plan for the child. Thus the lack of attention to the service system renders our discussion incomplete.

1

of African Americans increased by 4.7 percent, Hispanics by 30.2 percent, Asian American–Pacific Islanders (AAPIs) by 13.1 percent, and Native Americans by 9.8 percent (U.S. Bureau of the Census, 1998, 2000). Accordingly, youth of color increased in numbers and, in the period from 1995 to 2015, they are projected to increase at the following rates: AAPI youth, 74 percent, Hispanic youth, 59 percent, African American youth, 19 percent, and American Indian youth, 17 percent, compared to white, non-Hispanic youth, whose numbers are projected to decrease by 3 percent (Snyder and Sichmund, 1999). Thus, as service systems were slowly being restructured and the populations being served were undergoing dramatic demographic shifts, new questions arose regarding the appropriateness of services for these increasingly diverse groups of young people and their families. Although Knitzer's work had documented the inadequacies of service systems for youth with complex mental health needs, the situation for youth of color was even more distressing, with glaring inequities in access to services, appropriateness of treatments, and disparities of outcome. In response to these inequities, the designers of the CASSP system of care model then generated an additional framework for examining the cultural competence of these systems of care.

Systems of Care

Children and adolescents with mental health needs often present complex issues that involve different domains of youth functioning. From an ecological perspective, a child's socioemotional struggles may affect behavior in the family, in the school, in the peer group, in the community, and in other domains of the child's life. These domains in a child's life are often addressed by different child-serving systems. For example, psychological concerns are most often detected in the school and in primary health care systems. Or behavioral problems may lead to involvement in special education or with other public sector systems such as the juvenile justice or child welfare systems. A child's mental health issues impinge on multiple aspects of the child's life and, accordingly, multiple domains of the child's functioning. Youth with mental health needs appear in health care, mental health, juvenile justice, education and special

rell, 1993). In addition, in the juvenile justice or child welfare systems treatment may be based more on social control and removal from the family than support for positive growth and development (U.S. Department of Health and Human Services, 2001). Consequently, there are increasing numbers of youth of color with mental health problems experiencing high degrees of unmet need. In order to gain a more complete understanding of these mental health needs, we need to examine the experiences of these youth in some of these other child-serving systems that periodically interface with the mental health system.

The Juvenile Justice System

In the juvenile justice system, it has been estimated that 50 to 75 percent of youth in detention facilities suffer from mental health problems and are likely, without treatment, to become more vulnerable, volatile, and dangerous to themselves and others. The annual report of the Coalition for Juvenile Justice (2000) titled, "Handle with Care: Serving the Mental Health Needs of Young Offenders," indicates that 73 percent of youth in juvenile facilities reported mental health problems during screening; 57 percent had previously received mental health treatment; 55 percent had symptoms associated with clinical depression; 50 percent had conduct disorders; up to 45 percent had attention deficit–hyperactivity disorders, and many had multiple diagnoses. As least half of the youth with psychological disorders also had a co-occurring substance abuse disorder (Coalition for Juvenile Justice, 2000).

In a study of mental health needs among a stratified random sample of youth who were categorized according to level of involvement in the juvenile justice system, a high overall level of mental health needs for all samples was found (Lyons and others, 2001). The study included a community sample of youth on probation, a sample of youth in corrections incarcerated for their crimes, and a sample of youth adjudicated to residential treatment. Significantly higher mental health needs were found in both the incarcerated and residential treatment samples. Diagnosis of serious emotional disturbance using the Children's Severity of Psychiatric Illness scale revealed that 45.9 percent of the community sample, 67.5 percent of the incarcerated group, and 88 percent of the

Research has indicated that the disparities in treatment at all stages of juvenile justice involvement—referral or arrest, detention, formal processing, waiver to adult court, and disposition—weigh heavily against youth of color. The disparity is most pronounced at the beginning stages of involvement at the intake and detention decision points; however, when racial-ethnic differences are identified, they tend to accumulate as the youth are processed through the system. This "cumulative disadvantage" for minority youth within the juvenile justice system results in disproportionate minority confinement and overrepresentation of youth of color in secure juvenile corrections (Males and Macallair, 2000).

Gibbs (2001) summarizes the major findings from national reports on youth of color in the juvenile justice system.

- First, youth of color are more likely than whites to have contact with the juvenile justice system for a variety of reasons, including neighborhoods with higher crime rates, differential police policies and practices, racial profiling, and racial bias within the system (Poe-Yamagata and Jones, 2000; Snyder and Sickmund, 1999).
- Second, at the initial stages of involvement with the juvenile justice system, African American youth were overrepresented in arrests, in referrals to juvenile court, and in detention, as compared with white youth, although the latter were referred at more than twice the rate of black youth (66 percent versus 31 percent) (Poe-Yamagata and Jones, 2000).
- Third, even when the type of offense is similar, African American youth were more likely to be formally charged in juvenile court than white youth (Snyder and Sickmund, 1999). This is particularly notable in terms of drug-related offenses in which three-fourths of black youth are charged, compared with only half of white youth arrested for drug offenses (Poe-Yamagata and Jones, 2000).
- Fourth, minority youth offenders, in comparison to white youth, were significantly more likely to be waived to adult criminal court in all offense categories (Bazemore and McKean, 1994; Snyder and Sickmund, 1999). For drug offenses referred to juvenile court, this disparity is even more striking, with African American youth experiencing a

mining factor in detaining a youth after arrest (Davis, 1992; Gibbs, 2000). Police and probation departments in some jurisdictions allot "negative points" for alleged gang involvement during the risk assessment of arrested Latino youth.

Clearly, the outcomes for minority youth in the juvenile justice system are distressing and may be attributable to multiple factors (see Snyder and Sickmund, 1999). Although some have argued that this overrepresentation of minority youth in the justice system is merely a result of their showing more delinquency and criminal behavior, an accurate analysis is much more complex. Others suggest that different police policies and practices, location of offenses, reactions of communities, racial profiling, and racial bias within the justice system confirm that juvenile justice systems are not racially neutral. Increasingly, a double standard exists that incarcerates youth of color but rehabilitates white youth who commit comparable crimes (Males and Macallair, 2000).

Combining these findings with studies indicating a high incidence of mental health disorders among the juvenile justice populations (Coalition for Juvenile Justice, 2000) and the lack of effective services to meet the mental health needs of these youth, the vulnerability of youth of color in this particular system is significant. The studies suggest a dual pathway for white and minority youth who commit delinquent offenses, with white youth more likely to be diverted from the juvenile justice system into the mental health system for "treatment," whereas minority youth are more likely to be processed in the juvenile justice system for "punishment" (Dembo, 1988; Krisberg and others, 1987; Mason and Gibbs, 1992). Youth of color in juvenile and adult corrections are less likely than white juveniles to undergo a thorough psychological assessment and less likely to receive any therapeutic treatment (Coalition for Juvenile Justice, 2000; Hutchinson, 1990). However, among those evaluated, youth of color are more likely than white youth to receive a diagnosis of conduct disorder, antisocial personality disorder, or a substance abuse disorder than an anxiety or depressive disorder (Dembo, 1988; Hutchinson, 1990). There is significant concern that as more youth of color with undiagnosed or misdiagnosed mental health issues are entering the juvenile justice system, this particular system is in danger of becoming a warehouse for them (Kotler, 2001). Clearly, there is an urgent need to

Texas) found the proportion of African American children ranged from three times to over ten times the proportion of white children in care (Goerge, Wulczyn, and Harden, 1994). In contrast, white children constitute 66 percent of the U.S. child population, and they are 57 percent of the substantiated allegations, 46 percent of the child welfare population, 36 percent of the children in out-of-home care, and 52 percent of the child fatality cases.

In a national study of protective, preventive, and reunification services for children and their families in child welfare, researchers found that 56 percent of African American children are served in foster care and 44 percent in their own homes. In contrast, only 28 percent of white children are served in foster care and 72 percent receive services in their own homes. Forty-three percent of white children entering the child welfare system are out in less than three months, compared with 16 percent for African Americans. Similarly, only 31 percent of white children's cases are still open at eighteen months, compared with 64 percent of African Americans (Petit and Curtis, 1997).

These are significant contrasts in population groups, and explanations for these apparent differences in incidence of child maltreatment, service experience, and placement are complex. Lower income, poverty, and sociocultural differences in coping with poverty have been the conventional wisdom for explanations of child maltreatment. However, the relationship between low income and maltreatment does not hold for other lower-income minority groups such as Hispanic families, who are underrepresented in the child welfare system.

Additional studies document a pattern of uneven treatment among groups at different points in the child welfare system. Proportional representation should be expected throughout the system; however, this does not seem to be the case. In fact, for African Americans, disproportionate representation increases with further penetration into the system, suggesting either some direct system bias or a higher rate of failure of interventions with this population. For example, children of color are more likely than white children to be overrepresented in child maltreatment reports, based on the proportion of children of color in the child population. For children of color, these reports are more likely to be substantiated by child welfare authorities than those involving white children.

in service utilization, including systematic biases in referral patterns, differences in the receptivity and accessibility of providers, and cultural influences in help-seeking behaviors (Garland and others, 2000). In part, these inequities reflect historical differences associated with race in access to and utilization of public versus private child welfare services (Billingsley and Giovannoni, 1970). But they may also be related to the current resource allocation in child welfare, which favors more therapeutic services as opposed to concrete services such as employment counseling and preparation (Courtney and others, 1996). Family preservation services provide family-centered, home-based, short-term, intensive services to families at risk of having a child placed in out-of-home care (Wells and Biegel, 1991). The objective of these services is to maintain the child in the family's home.

Given the large number of children of color in out-of-home care, there is renewed interest in examining the effectiveness of family preservation services for families of color. In an evaluation study of family preservation services in Washington state, families of color experienced fewer out-of-home placements (18.2 percent) with the provision of family preservation services than white families (29.8 percent), suggesting that this family preservation model may be more culturally appropriate for families of color than traditional child welfare and mental health services, as it provides a combination of concrete and clinical services in clients' homes (Fraser, Pecora, Haapala, 1991).

In terms of adoption, African American children are adopted at a much lower rate than white children. One study found that of 2,110 children listed in the New York State Adoption Services Photolisting between 1985 and 1989, children of color had longer waits and were less likely to be placed compared with white youth (Mont, 1991). Two pieces of federal legislation, the Multiethnic Placement Act of 1994 and the Interethnic Placement Act of 1996, were passed to attempt to facilitate the adoption of youth of color such that states and other entities involved in foster care or adoption placements, and that receive federal financial assistance under Title IV-E, Title IV-B, or any other federal program, cannot delay or deny a child's foster care or adoptive placement on the basis of the child's or the prospective parent's race, color, or national origin (U.S. Department of Health and Human Services, 2001). One

ter care and the emotional turmoil of living in an unpredictable, unstable environment (McCarthy and Woolverton, 2001).

The Special Education System

The overrepresentation of children of color in special education and the quality of their education has been a significant and ongoing issue in public education for the past thirty years. Disproportionate representation of youth of color, particularly African American students, remains a controversial and unresolved issue. The Individuals with Disabilities Education Act (IDEA) (Public Law, 105-17) mandates a free appropriate public education (FAPE) for all individuals with disabilities. The law requires nondiscriminatory assessment, identification, and placement of children with disabilities. These children are entitled to special educational services under IDEA; however, children who achieve poorly because of differences related to environmental disadvantage or ethnic, linguistic, or racial differences are not to be identified as disabled.

The manner in which state and local education jurisdictions implement IDEA and provide educational equity and FAPE has been challenged repeatedly in legal arenas and public discourse. A history of overrepresentation of minority children placed in special education has been documented as discriminatory practice and an infringement of students' civil rights. Yet communities and families of color have also relied on this law to provide special education services for their children who may evidence an emotional, behavior, or learning disorder and require this policy to access appropriate educational and mental health services. Thus the dilemma for special education under IDEA is to identify students with equity and nondiscrimination and to provide the culturally appropriate services for eligible students of color, under IDEA, to achieve good educational and socioemotional outcomes.

Socioeconomic issues play a role in the educational careers of children of color and in their experiences with special education. Poverty affects minority students' preparedness and performance in school (Duncan, Brooks-Gunn, and Klebanov, 1994; Entwisle and Alexander, 1993). Numerous studies have focused on the assessment process and test bias as primary reasons for minority overrepresentation in special education. However, a recent review of the literature

disability. In primary health care, about 25 percent of people have a diagnosable mental disorder, most commonly anxiety and depression (Olfson and others, 1997). In terms of primary care, there are more than 150 million pediatric visits each year (Woodwell, 2000). Most children with mental health problems see their primary care providers rather than mental health specialists. Primary care physicians identified about 19 percent of all children they see with behavioral and emotional problems (Kelleher, 2000). African American and Hispanic children are identified and referred at the same rates as other children. Culturally diverse families with mental health issues often seek care for these problems in the primary health care system. In part, this is due to greater familiarity and less stigma associated with health care settings and culturally based explanations attributing emotional and psychological concerns to a physical basis. Although these children are referred at the same rate to mental health services, they are significantly less likely to receive specialty mental health services or psychotropic medications (Cuffe and others, 1995; Kelleher, 2000).

Currently, there is a lack of information on the psychological problems, services, and treatments for children of color presenting in the primary care system. This information would be critical for understanding better the interface between health care and mental health services. However, there are studies that examine ethnicity in the context of children's general health and use of services. These data highlight striking ethnic disparities in children's health and use of health services. For example, a study based on the National Health Interview Survey (Flores, Bauchner, Feinstein, and Nguyen, 1999) found that Native American, black, and Hispanic children are poorest (35 to 41 percent below poverty level versus 10 percent of white children), least healthy (66 to 74 percent in excellent or very good health versus 85 percent of white), have fewer doctor visits, and are more likely to have excessive intervals between visits. Hispanic subgroup differences on these variables surpass differences among major ethnic groups; nearly all ethnic group disparities for children persisted, even after adjustment for family income and parental education. Specific analyses found that Native American and black children have twice the odds of having suboptimal health compared with white children, followed by AAPI children and Hispanic children. Among the Hispanic subgroups, Puerto Rican and Mexican ancestry were significantly associated

through private means, for immigrant youth there are gaps in the net. Between 1995 and 1999 the number of low-income noncitizens on Medicaid fell from 19 percent to 15 percent. Currently, twenty-two percent of children of immigrants are uninsured (Kaiser Commission on Medicaid and the Uninsured, 2000). The immigrant population is especially vulnerable to inadequate insurance due to welfare reform and other policy changes that created a five-year ban on Medicaid eligibility for newer immigrants (after 1996). Other prohibitive factors include language barriers, confusion and apprehension on the part of noncitizens regarding becoming a public charge, and concerns regarding eligibility for citizenship (Kaiser Commission on Medicaid and the Uninsured, 2000).

These disparities in health access and outcome for children of color further complicate the identification and treatment of mental health disorders. Primary care services, similar to schools, are frontline providers for these children and their families. However, already confronted with these significant disparities in general health access and utilization, it is expected that prevention and intervention for mental and behavioral health problems will be even more limited.

The Mental Health System

In one of the largest national studies to date on children's use of mental health services, Pottick (2002) reports that more than 1.3 million children under the age of eighteen (or 1 of 50 youth) received mental health services in the United States during 1997. This is nearly double the number of children who received treatment in 1986, although the extent of unmet need in the United States is still unknown. This increase in rate of service used may not be reflected equally among poor or minority children or those in socially stressed or resource-deprived communities. In terms of race and ethnicity, more white (65 percent) than black (19 percent) or Hispanic youth (14 percent) received mental health services. In addition, the majority of youth (51 percent) who received mental health services in 1997 were adolescents thirteen to seventeen years old; 40 percent were between six and twelve; and a surprising 9 percent were preschoolers. Primary presenting diagnoses were disruptive behavior disorder (31 percent), mood disorder (21 percent), and

cent), attention deficit/hyperactivity disorder (11 percent), marijuana dependence or abuse (9 percent), major depressive disorder (5 percent), and other substance dependence or abuse (4 percent). In this population of youth, there was considerable comorbidity involving substance abuse.

In terms of service utilization, the few studies examining this variable indicate that American Indian children rarely receive services in the specialty mental health system but more likely through juvenile justice and inpatient facilities and in schools (Costello and others, 1997; Novins, Fleming, Beals, and Manson, 2000). Services for substance-related problems were most commonly provided in residential settings.

Studies of mental health problems for Latino youth reveal a consistent pattern of significantly more mental health problems than white youth. More anxiety-related problems, delinquency problem behaviors, and depressive symptoms and disorders were reported in multiple studies (Vazsonyi and Flannery, 1997; Roberts and Chen, 1995; Roberts and Sobhan, 1992). However, the few studies that examine the use of mental health services indicate that Latino youth use these services significantly less than white youth, have fewer lifetime counseling visits, and are underrepresented in the use of outpatient mental health facilities (Pumariega, Glover, Holzer, and Nguyen, 1998; Bui and Takeuchi, 1992).

There are few epidemiological studies on the mental health disorders of AAPI children and adolescents. The few studies that have been conducted with small samples of Asian Americans find few differences between this population and that of white youth, although in a study conducted by the Commonwealth Fund, Schoen and others (1997) found depressive symptoms in girls in grades 5 through 12 to be highest in Asian American females (30 percent), as compared with white females (22 percent), African American females (17 percent), and Hispanic females (27 percent).

Even though the overall prevalence of mental health problems and disorders is not different from that of other groups, Asian Americans have the lowest rates of utilization of mental health services among ethnic populations for both adults and youth (U.S. Department of Health and Human Services, 2001). When Asian Americans do utilize services, they are generally more severely ill