Chapter Seven

Disparities in Access to Services and Delivery of Culturally Competent Services

Symposium
Disparities in Children's Mental Health Systems of Care

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Symposium Introduction

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Disparities exist in mental health service utilization and in treatment outcomes. The President's New Freedom Commission on Mental Health recommends eliminating disparities by improving access to culturally competent care and care in remote areas of the country. In order to achieve these goals, it is necessary to have a better understanding of who is affected by disparities, the context in which disparities occur, and the characteristics of programs and practices that are effective in reducing disparities. This symposium presents findings from three related studies that examine disparities among children referred for mental health services in the Comprehensive Community Mental Health Services for Children and Their Families Program initiative (CMHI) of the Center for Mental Health Services (CMHS). The first paper reviews key findings regarding racial, gender, and geographic disparities among children referred to the CMHI. The second paper examines whether racial, ethnic and income differences exist between children served by individual CMHI program sites and the children residing in that site's geographic catchment area. The third paper examines racial and ethnic differences among caregivers in their perceptions regarding the provider's understanding of cultural competence and the importance caregivers place on cultural competence. Research, service, and policy implications are introduced for discussion in each paper.

Disparities in Need and Disparities in Outcome: What Have We Learned to Date through the National Evaluation?

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Introduction

The significance of health disparities has been emphasized recently by federal public health agencies/organizations. The 2003 New Freedom Commission on Mental Health Report lists six goals as the foundation for transforming mental health care in America (New Freedom Commission on Mental Health, 2003). Goal 3 of this report specifically addresses the elimination of mental health disparities including improved access to culturally competent quality care and quality care in rural, geographically remote areas. Despite this recent emphasis on health disparities, the extent to which disparities exist within children's mental health remains understudied. This paper summarizes disparity related findings from a national evaluation of a federally funded children's mental health program.

Defining Disparities. Varying conceptual definitions of disparity can be found within the public health literature. A review of the literature reveals that the terms "inequality," "variation," "inequity" and "disparity" have all been used interchangeably (Carter-Pokras & Baquet, 2002). In the 2001 National Institutes of Health Strategic Plan to Reduce and Ultimately Eliminate Health Disparities, health disparities were defined in terms of differences in incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups (Department of Health and Human Services, 2001). Within the Center for Mental Health Services (CMHS) national evaluation, disparities have primarily been examined with regard to differences in presenting problems, need, outcomes and service use. More specifically, research and evaluation efforts have focused on how presenting problems, need and clinical outcomes differ as a result of differences in gender, race/ethnicity, geography, and socioeconomic status.

Methods

Data for the studies described in this paper were drawn from the child and family outcome study of the CMHS National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. Funded by the Substance Abuse Mental Health Services Administrations' (SAMHSA) Center for Mental Health Services (CMHS), this initiative provides five-year grants to communities to develop and implement local systems of care targeting children with serious emotional disturbances.

Children and youth ages 5 to 18 are enrolled in the longitudinal outcome study of the National Evaluation. This component of the National Evaluation examines how systems of care affect child clinical/functional status and family life. Caregivers of all children and youth ages 11 and older are interviewed within 30 days of the child's entry into services and at six-month intervals thereafter (for up to 36 months). This summary provides an overview of key findings to date from studies examining disparity through analysis of data from the longitudinal outcome study.

Results

Race/Ethnicity

Disparities among varying racial/ethnic groups of children and youth enrolled in the National Evaluation have been examined in several cross-sectional studies. These studies have shown differences in diagnosis, presenting problem and service use. In a study examining clinical characteristics of Asian American children and youth, Asian American children were found to be less likely to have diagnoses of depression or Attention Deficit-Hyperactivity Disorder than their non-Asian American counterparts. In contrast, they were more likely than non-Asian American children to have diagnoses of anxiety or adjustment disorder, and more likely to have severe functional impairment in the areas of community role performance, self harmful behavior and thinking (Nguyen, Arganza, Huang, Liao, Nguyen et al., 2004).

Differences in diagnosis have also been found between African American and White children enrolled in systems of care. Disruptive behavior disorder diagnoses were more prevalent among African American children when compared to White children. In addition, Whites were more likely to have a mood disorder diagnosis than African American children (CMHS, 2003).

Racial disparities have also been identified in regard to medication use. An examination of psychotropic medication use among children and youth enrolled in the National Evaluation revealed a disparity in the receipt of psychotropic medications (Foster & Gifford, 2006). Although initial findings from this study suggested that Whites were more likely than African Americans to receive psychotropic medication, further analysis revealed that these differences were significantly influenced by where youths lived. Through use of a multi-level decomposition analytical approach, it was ultimately determined that where youths lived was a larger determinant of care than race. Within the study sample, African Americans were concentrated in areas where youth were less likely to receive medications.

Geography

Disparity in need and outcomes as determined by differences in geographic location has also been examined among children in the National Evaluation. A 2003 cross-sectional comparison of rural and nonrural communities revealed significantly higher levels of functioning impairment among those children served in nonrural communities (Walrath, Miech, et al., 2003). Children served in nonrural communities had significantly higher impairment in School, Community, Substance abuse and Overall functioning impairment as measured by the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000).

In contrast to the above findings, a longitudinal study assessing level of functioning impairment using the CAFAS found children from rural communities had significantly higher levels of impairment at six months post intake than those children from urban/nonrural communities (CMHS, 2003).

Gender

Disparities in need have been found within the National Evaluation sample in regard to gender. Cross-sectional studies have found differences in diagnoses between males and females upon entry into services (Nguyen, Arganza, Huang, & Liao, 2004). Females were more likely to have an anxiety or depression/dysthymia diagnosis or be diagnosis deferred. Males were more likely to have an ADHD or conduct related diagnosis. Males were also more likely to display comorbidity and of those children with comorbidity, males were more likely to have either a substance abuse or conduct related disorder as their secondary diagnosis.

Socioeconomic Status

Few studies have been conducted examining the relationship between socioeconomic status and disparities. An examination of behavior, functioning and service use based on family income (above/below poverty threshold of $18,100 for a family of four) revealed differences in the number and types of services received, yet no difference in functioning impairment or behavioral problems (Gyamfi, 2004). Families living below the poverty threshold were more likely to receive fewer services than those living above the poverty threshold. Families living above the poverty threshold were more likely to receive residential treatment services and medication management.

Summary

Analyses of National Evaluation data have revealed disparities in both need and outcomes. Disparities in behavioral and functional outcomes, needs and service use have been found to be influenced by various factors including race, gender, socioeconomic status and geographic location. This paper has summarized disparity related studies conducted to date using data from the National Evaluation. Although some progress has been made in the examination of disparities within the data, disparity related topics remain understudied.

Future disparity analysis and dissemination efforts should begin with a comprehensive literature review, and should further examine the relationship between disparities and factors such as race, gender, socioeconomic status, and geographic location. In addition, data from other study components of the National Evaluation including the system of care assessment and the cultural competence study should be incorporated into future disparities research. Analysis of data from these components of the evaluation may provide valuable insight into the relationship between system- and practice-level factors and disparities in need, outcomes, quality of care and access.

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The Potential Role of CMHS Program Sites in Addressing Mental Health Disparities

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Introduction

Disparities in children's mental health are present across socioeconomic strata and race/ethnicity. Specifically, children and adolescents who are poorer are more likely to have serious emotional difficulties, as are Black and Hispanic children in comparison to Whites (Mark & Buck, 2006). Both the National Institute of Mental Health and, more broadly, the National Institute of Health prioritize the reduction of disparities in health, including mental health (Office of Special Populations, 2001). In fact, the National Institute of Health ranks disparity reduction as one of its top three goals (Department of Health and Human Services, 2000). However, despite intentions to reduce known disparities in child and adolescent mental health, national programs explicitly designed to reduce them are lacking.

This paper examines the potential of the federally funded Comprehensive Community Health Services for Children and Their Families Program, hereafter referred to as the Children's Mental Health Initiative (CMHI), to work to meet this goal, though not designed expressly for this purpose. More than 70,000 children and their families have received services through the Comprehensive Community Mental Health Services for Children and Their Families Program to date. This program, funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS), is based on the system-of-care service delivery model developed by Stroul and Friedman (1986), which recommends that multi-agency, coordinated, community-based, family-driven, individualized services be delivered in a culturally sensitive and appropriate manner, in the least restrictive setting possible.

Method

The analysis examines whether the funded CMHI communities successfully reach disadvantaged youth by comparing the demographics of CHMI enrollees to the demographics of their respective catchment areas. If the CMHI communities disproportionately serve children who are poorer and in minority groups, then it may actually be acting as one of the largest and most influential programs to reduce health disparities, to the extent that it successfully treats serious emotional disorders among its clients.

The data for this study come from two sources: (a) the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program and (b) the U.S. Census 2000. As part of the national evaluation, structured interviews were conducted with caregivers and youth. Descriptive data (e.g. race, gender, income, etc.) were collected on all children who were referred to the system of care. A detailed description of the national evaluation data collection procedures can be found elsewhere (CMHS, 2001; Holden, Friedman & Santiago, 2001).

The current study uses descriptive national evaluation data gathered from communities that were funded between 1997 and 2000, and enrolled children between 1997-2005 in urban, rural, and Native American communities across the United States. Each community, through the grant application process, needs assessment, and systematic and periodic qualitative assessment, provided a description of its designated catchment service area. This information was used to extract corresponding population-level race/ethnicity and household income information from the U.S. Census 2000. The Census 2000 Sample File 3, which consists of population data collected in a sample of households and then weighted to reflect the total population, was used to obtain the racial and household income composition of each community's catchment area. A more detailed description of U.S. census data collection procedures may be found elsewhere (US Census Bureau, 2002).

The sample (N = 19,189) for the current study includes children between ages 5 and 18 years who were referred into a funded system of care community between 1997 and 2005. Children were referred into the system from a variety of sources, including mental health (29.7%), juvenile justice (15.2%), education (17.2%), child welfare (13.4%), family (10.5%), and other sources (14.0%). The sample was predominately male (66.4%) and the mean age was 12.4 years (SD = 3.4).

Statistical Analysis

The goal of these analyses was to compare the populations of children and adolescents receiving mental health services to that of their respective provider catchment areas with regard to poverty and race/ethnicity (White, Black, Hispanic). First, descriptive statistics were examined. Then, the percentages of White, Black, and Hispanic children and the percentage of households living below poverty level in each catchment area were calculated using data from the 2000 U.S. Census. The same calculations were completed for children receiving services at each of the program sites. Each percent was converted to odds, which were then used to calculate odds ratios.

Results

The analysis indicates that CMHS programs are successful in disproportionately recruiting children within their catchment areas who are poor and who are African-American. In every single one of the 45 programs in the analysis pool, program enrollees were more likely to be poor than children in the corresponding catchment area. On average, the odds of living in poverty were about six times higher for children enrolled in CMHS programs as compared to children in the corresponding catchment area. The majority of CMHS programs also disproportionately recruited African-American children from their catchment areas, so that youth in the programs were about twice as likely to be African-American as youth in the corresponding catchment areas. The disproportional numbers of poor and African-American youth in the programs resulted from independent processes; after controlling for race/ethnicity CMHS youth were still significantly more likely to be poor than youth in the catchment area, and after controlling for poverty CMHS youth were still significantly more likely to be African-American.

Discussion and Conclusion

In this study we examined whether funded CMHI programs disproportionately serve children and adolescents who come from poorer families and minority race/ethnic groups. If so, these programs may be helping to reduce disparities in child and adolescent mental health, to the extent that they are effective. The analysis of this study is unique because it compared the sociodemographic distribution of

Figure 1
Log Odds Ratio for Percent Poor in the CMHS Program Compared to the Targeted Catchment Community

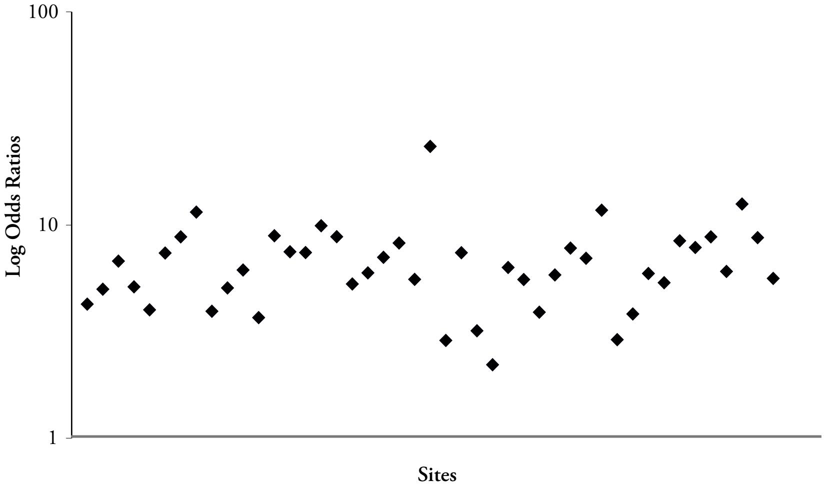
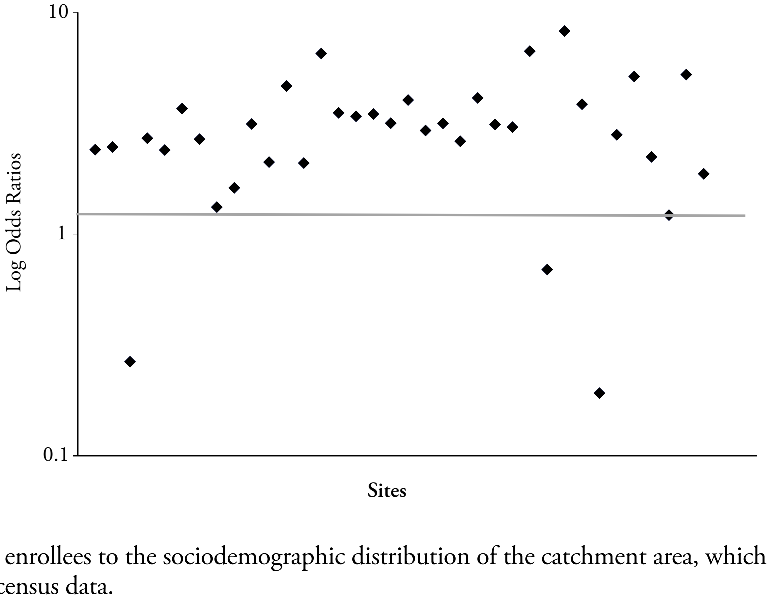


Figure 2
Odds Ratio of the Percent African-American in CMHS Program Compared to Targeted Catchment Community



the program enrollees to the sociodemographic distribution of the catchment area, which were coded and matched to census data.

To date, over 70,000 children with serious emotional disorder have been served by The Comprehensive Community Health Services for Children and Their Families Program, and the results of this study suggest that the program may be playing a substantial role in reducing mental health disparities across income and race. These results warrant consideration of the CMHI program as one of the most influential projects currently in place to address health disparities. Such recognition, if further justified by future research, could help to set disparity reduction as a major goal of the program and serve to facilitate discussion and re-organization to achieve this goal more effectively. It would also help link the program to related funding streams, on-going programs, and large-scale initiatives so that it could reduce health disparities further.

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Racial and Ethnic Differences in Caregivers' Ratings on the Cultural Competence of Their Service Providers in Systems of Care

Robert L. Stephens, Ye Xu & Phyllis Gyamfi

Introduction

There is increasing evidence to support the system of care philosophy which asserts that services delivered to culturally diverse children and families should be provided in a culturally appropriate and respectful manner, and that cultural values and traditions should be considered and incorporated into service planning and provision (Cross, Bazron, Dennis, & Iasscs, 1989; Davis, Johnson, Barraza & Rodriguez, 2002; Hernandez & Issacs, 1998). Historically, service systems have not effectively addressed the mental health needs of minority children and families. Among the barriers faced are disparities in health care access and quality, lack of appropriate services, high cost of services, and stigma related to mental illness (Huang et al., 2005). Other barriers include mistrust of service providers, fear of treatment and racism and discrimination (Huang, 2002).

Method

The participants in this study were 479 caregivers and their children enrolled in system of care services who participated in the longitudinal outcomes study of the Children's Mental Health Initiative (CMHI), administered by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), in communities funded from 2002-2004 and who had complete data on all variables included in the current study.

The Cultural Competence and Service Provision Questionnaire (CCSP) developed for the national evaluation served as a measure of cultural competence. It assesses the importance of culture to caregivers and ratings of their providers' understanding, knowledge, and inclusion of the family's culture in service provision. Ratings of importance of providers' cultural understanding ranged from 1, *not at all important*, to 5, *extremely important*. Ratings of providers' cultural practices range from 1, *never*, to 5, *always*. In addition, aspects of the service experience (e.g., access, satisfaction, etc.) were assessed using the Youth Services Survey for Families (YSS-F; Brunk, Koch, & McCall, 2000). Child strengths were measured using the Behavioral and Emotional Rating Scale – Version 2 (BERS-2; Mooney, Epstein, Ryser, & Pierce, 2005).

Design and Analysis

This study examined differences in ratings of White, African American, Hispanic, American Indian and Native Hawaiian/Pacific Islander families on the level of importance of culture and the extent to which culture is incorporated in the provision of services[1]. One-way analysis of variance (ANOVA) was used to examine the influence of race/ethnicity on ratings of importance and frequency of experiencing cultural competence in services. Predictors of ratings of importance and frequency of cultural competence in services at six months were examined using multiple regression with demographic and clinical characteristics collected at intake as covariates. Finally, multiple regression was used to examine importance and frequency of cultural competence in services at six months as predictors of satisfaction with services at six months. Covariates were entered in hierarchical order with demographic variables entered in the first block, clinical variables in the second block, and for satisfaction, importance and frequency of culturally competent service provision in the third block.

Results

The racial/ethnic composition of the sample of caregivers was 48.4% White; 35.1% Black; 10.9% Hispanic; 3.3% American Indian/Alaska Native; and 2.3% Hawaiian or other Pacific Islander. Caregivers

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[1] *Asian caregivers and youth were excluded from analysis due to a very limited sample size.*

were mostly female (93.7%), and 80% were the biological parent of the child. Caregivers' average age was 39.7 years old (*SD* = 9.9). Most had at least a high school education or GED (84.3%), and 44.1% reported family incomes of less than $15,000 per year.

Over two-thirds of the children were boys (69.3%), and their average age was 11.8 years old (*SD* = 3.3). Most were in the custody of their biological parent(s) (81.2%). The two most frequent diagnoses were Attention Deficit-Hyperactivity Disorder (43.1%) and mood disorders (34.4%). The largest proportion of youth were referred to services from schools (31.9%), followed by mental health agencies (22.8%) and caregivers (14.0%).

Overall, caregivers' ratings of the importance of their providers' understanding the family's culture at six months following entry into services indicated that, on average, they considered it less than moderately important (*M* = 2.7, *SD* = 1.2). However, while the overall caregiver ratings suggested providers' understanding of the family's culture was not very important, their ratings of the frequency of experiencing culturally competent service provision indicated that providers almost always incorporated the family's culture while providing services during the first six months (*M* = 4.6, *SD* = 0.6).

As Table 1 shows, ratings of the importance of providers' understanding of the families' culture differed as a function of the caregiver's race/ethnicity and this difference was significant, $F(4, 474) = 18.6$, $p < .001$. Specifically, caregivers who were White rated their provider's understanding of their culture as being significantly less important than caregivers of all other racial/ethnic groups. Caregivers' ratings of the frequency with which their providers implemented culturally competent practices in service provision did not differ significantly by race or ethnicity at six months after services.

Table 1
Mean Ratings of Caregiver Perspectives on Cultural Competence of Service Provision at 6 Months and 12 Months in Communities Funded in 2002-2004 (*N* = 479)

	American Indian/Alaska Native (n = 16)	*African American (n = 168)*	*Native Hawaiian/Other Pacific Islander (n = 11)*	*White (n = 232)*	*Hispanic (n = 52)*
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*
Importance of provider's understanding of family's culture	3.0 (1.1)	3.2 (1.1)	2.9 (1.4)	2.3 (1.1)	3.2 (1.2)
Frequency of provider's culturally competent practices	4.6 (0.7)	4.6 (0.5)	4.5 (0.5)	4.5 (0.7)	4.7 (0.4)

Because of limited sample sizes for participants who identified as American Indian/Alaska Native or Native Hawaiian/Other Pacific Islander, subsequent analyses were limited to caregivers and youth who identified as White, African American, or Hispanic. This resulted in a subsequent analysis sample of 452 caregivers. Of these, 232 were White, 168 were African-American, and 52 were Hispanic. Other demographic characteristics of this sample were similar to the full sample.

Results of multiple regression analysis to examine the ratings of importance of cultural competence in services at six months indicated, overall, poor model fit, $\Delta F(4, 440) = 0.8$, $p = .525$; $R^2 = 0.16$. Results indicated that only race/ethnicity significantly predicted importance with both Hispanic and Black caregivers rating importance higher than White caregivers. Multiple regression analysis results for ratings of frequency of cultural competence in services at six months also indicated poor model fit, $\Delta F(4, 440) = 1.2$, $p = .322$; $R^2 = 0.02$. Only caregivers' ratings of their children's strengths significantly predicted frequency of culturally competent service provision with greater strengths associated with high ratings of frequency.

Results of the final multiple regression analysis model for caregiver ratings of satisfaction with services at six months following entry into services are presented in Table 2. Model fit was good, $\Delta F(2, 438) = 73.3, p < .001; R^2 = 0.30$. Youth age significantly predicted satisfaction, with caregivers of older youth reporting greater satisfaction. Higher caregiver ratings of children's strengths also were associated significantly with higher satisfaction with services. Finally, mean ratings of importance and frequency of culturally competent service provision were both significant predictors of satisfaction with services. Higher ratings of both importance and frequency of culturally competent service provision were associated with higher levels of satisfaction with services.

Table 2
Results of Multiple Regression Analysis for Ratings of Satisfaction with Services

	Std. Coeff.	*Significance*
Caregiver Age	-0.016	n.s.
Youth Age	0.093	.043
Black (1= yes)	0.039	n.s.
Hispanic (1= yes)	0.013	n.s.
Gender (1= girl)	0.046	n.s.
Caregiver Education (1= high school or >)	-0.077	n.s.
Annual Family Income (1= below $15K)	-0.039	n.s.
Mood Disorder Diagnosis (1= yes)	-0.009	n.s.
ADHD Diagnosis (1= yes)	0.041	n.s.
Total Number of Risk Factors	0.005	n.s.
BERS Strengths Index - Caregiver	0.119	.004
Mean Importance Rating	0.121	.006
Mean Frequency of Experience Rating	0.475	< .001

$n = 452, \Delta F(2, 438) = 73.3, p < .001, R^2 = 0.30$

Conclusions

It is evident from these findings that culture is a very important issue for minority families. Given the importance of culture, providers must strive to incorporate their consumers' cultures into service provision. Because disparities in mental health care can arise from cultural insensitivity, the prevention and treatment of mental health should be guided by culturally competent practices. The findings from this study have implications for improving service provision in systems of care. Importantly, all the caregivers in this study who received services in systems of care indicated consistent experience of the incorporation of cultural values and beliefs in their services, and this led to greater satisfaction with services during the first six months. Federal, State and local child-serving agencies should work toward improving the evaluation of disparities in programs; developing measurable cultural competence standards for assessing programs and staff; creating diversity in the workforce that reflects the population being served; developing cultural competence goals for the system; and providing on-going training and technical assistance on cultural competence.

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How and Why Does Health Service Access Vary Across Racial/Ethnic Groups for Children in the Child Welfare System?

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Introduction

There is evidence that non-white children in the child welfare system may have especially poor access to health services, especially mental health (Garland & Besinger, 1997; Garland, Landsverk, & Lau, 2003; Hurlburt et al., 2004; Leslie et al., 2005; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Zima, Bussing, Yang, & Belin, 2000). The current study addresses this issue by comparing counseling as well as five other types of health service access among non-Latino/a white, non-Latino/a black, and Latino/a children in the child welfare system. We also use multiple regression to explore possible sources of the most salient disparity identified, which was indeed in counseling. The result provides a more complete depiction of health service access for children in the child welfare system and possible reasons for barriers to access.

Methods

The descriptive sample included 2,505 white, black, and Latino/a children in the initial 1999 cohort of the National Survey of Child and Adolescent Well-Being (NSCAW) who received child welfare services and for whom information about case management was available from caseworkers. Of these children, 1,063 (42%) were non-Latino/a whites, 949 (38%) were non-Latino/a blacks, and 493 (20%) were Latino/as. These children were served by a total of 86 child welfare agencies whose directors had participated in interviews about agency management practices and policy contexts (Dowd et al., 2002). The sample in the multiple regression was restricted to 537 children in 69 child welfare agencies whom caseworkers had reported were in need of behavioral counseling.

Caseworker perceptions were used to measure need for six types of services: 'health,' immunization/check-ups, vision, hearing, dental, and counseling for an emotional, attentional, or behavioral problems. Service access was coded as 1 when a caseworker who had referred a child for a service in a given area also reported that the child had received that service, and 0 if the child did not receive the service.

We measured caseworker effort separately relative to each area of need for each child as the percentage of the following actions taken to secure services: suggesting that child should get services; providing child's caregiver with names and numbers of service providers; making an appointment for child; accompanying child to the appointment; following up to see if service was provided; and other.

Two measures indicated agency accountability, which was anticipated to potentially decrease disparities: the presence of a consent decree as the result of a lawsuit, and accreditation by an external reviewing body. Local resource availability measures were metropolitan county status and the numbers of child psychiatrists, psychologists, and social workers relative to the county's population of youth under the age of 18. Agency service areas generally coincided with county boundaries.

Descriptive statistics were generated using probability weights allowing generalization to children throughout the U.S. child welfare system (NSCAW Research Group, 2002). STATA's complex survey commands also allowed accommodation for nine geographic strata and for clustering of children within primary sampling units, defined as the areas—typically counties—served by a single child welfare agency.

Behavioral counseling was the focus of additional investigation because black children had notably lower access than white children. Nonsignificant agency-level variation in children's receipt of counseling indicated that mixed effects modeling was not appropriate. We therefore again used STATA's complex survey commands in the multiple logistic regression, predicting counseling access to accommodate stratification and clustering of children within agencies.

Findings

Among the six domains of services examined, there were scattered differences across racial/ethnic groups in caseworkers' perceptions of either need or access contingent upon need. Caseworkers were more likely to believe that more black children (51.6%) than white children (42.9%) needed immunizations or check-ups they were currently not receiving (i.e., new services), and were more likely to report that more Latino/a (15.2%) than white children (8.3%) needed vision care. They were also more likely to believe that more white children (34.5%) than black children (24.1%) needed behavioral counseling.

In general, access was very high for services to which child welfare agency staff had made referrals and was comparable across racial/ethnic groups. The biggest gap was in counseling, with black children receiving recommended counseling services less frequently than white children (84.8% versus 93.6%). Latino/a children also had slightly better access to recommended vision care than white children (99.5% versus 95.5%). There were no differences across children's racial/ethnic groups in the potentially relevant child welfare agency management factors examined. Children of all racial/ethnic groups were equally likely to be in agencies operating under consent decrees and with accreditation. There was also no difference across racial/ethnic groups in the number of ties their child welfare agencies had with mental health agencies and schools.

White children were significantly less likely than black children or Latino/a children to live in metropolitan counties (69.9% versus 97.1% and 92.4%, respectively). Perhaps because of their relative rurality, white children tended to be in counties with fewer psychologists than either black or Latino/a children (121.1 per 100,000 children for white children, versus 185.1 for black children and 189.2 for Latino/a children). White and Latino/a children were on average in counties served by fewer social workers than were black children (538.2 and 658.6 versus 873.8 per 100,000 children).

The multiple logistic regression model revealed that the absence of public health insurance was associated with lower odds of receiving counseling. This was most notably true for children who were uninsured (*OR* 0.07, $p < 0.001$), and to a lesser extent for children with private insurance (*OR* 0.30, $p < 0.05$). A history of sexual abuse (*OR* 4.08, $p < 0.05$), being 11 years old or older versus being younger (*OR* 3.46, $p < 0.05$), and being the focus of a high level of caseworker effort to secure services (*OR* 5.03, $p < 0.05$) were all associated with higher odds of receiving recommended counseling services.

Conclusion

Overall, findings indicate generally comparable health care access among children in the child welfare system, with differences not consistently disadvantaging any one group. Access to counseling, however, was notably lower for black children than for white children.

Findings about the potential effects of case management on service access were mixed. The current analyses did find that caseworkers were more likely to perceive white than black children as needing counseling, but didn't find that caseworkers tried any harder to get services they saw as needed for one group than for another. Even among children referred for counseling, however, black children had lower rates of access. The strongest predictor in multiple regression was children's insurance status. One approach to this problem might be to allocate funds for child welfare agencies to pay for counseling for children in their care, potentially augmenting payments for children with public insurance. This might be managed in some states through their Medicaid Title IV-E child welfare waivers, which allow greater flexibility in use of Medicaid funds for children in the child welfare system. Results also indicate that caseworker efforts do matter, despite typically constrained circumstances.

In the multiple regression analyses predicting access to counseling, neither any aspect of agency management nor county level resource availability was significant. We did not replicate Hurlburt et al.'s (2004) association between interagency ties and mental health service access, possibly because of differences in the measurement of services, with Hurlburt et al. having examined all specialty outpatient mental health use and the current analyses examining only new services received after child welfare agency referral.

Overall, this study indicates that race/ethnicity is generally not correlated with differences in health service access for children in the child welfare system. When such differences do exist, they appear to be explained by a combination of factors that include specific aspects of child risk, financial resources, and caseworker effort. Future research should continue to investigate the reasons why black children receive fewer needed counseling services. In addition, greater enrollment in public health insurance and proactive case management may improve access for all of these vulnerable children.

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Race/Ethnicity and Psychotropic Medication Prescribing Patterns for Youth

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Background

In the past decade, the rate of prescribing psychotropic medications to children and adolescents has increased at a surprising rate, especially after 1999 (Thomas, Conrad, Casler & Goodman, 2006). In 2001, 8.3% of office visits resulted in psychotropic prescriptions, up from 3.4% in 1994 (Thomas et al., 2006). Adolescents have shown the highest increases in rates of psychotropic use, particularly the use of selective serotonin reuptake inhibitors (SSRIs) (Thomas et al., 2006). By 1996, antidepressants were the second most commonly prescribed medications (Zito, Safer, dosReis, Gardner, Magder, et al., 2003). After controlling for sociodemographics, children and adolescents were found to be 3.56 times more likely to use an antidepressant in 1996 than in 1987 (Olfson, Marcus, Weissman & Jensen, 2002). Parents often seek initial mental healthcare for their children through a primary care physician. However, physicians have been found to prescribe psychotropic medications at higher rates than psychiatrists (Patel, Crimson, Hoagwood, Johnsrud, Rascati, et al., 2005). It is unclear whether the increases in psychotropic prescriptions for children and adolescents are a result of greater access to appropriate treatment or an over reliance on medications (Thomas et al., 2006). Furthermore, research suggests that there may be racial and ethnic disparities in the prescription rate of these drugs for children and adolescents. Thomas et al. (2006) found that between 14 and 26% of office visits resulting in the prescription of psychotropic medications were not associated with a mental health diagnosis. The research questions for this study were: (1) What are the demographic and diagnostic characteristics of different child and adolescent racial and ethnic populations? (2) Does provision of second-generation antipsychotic and newer antidepressant medication vary by race/ethnicity? and (3) What are the predictors of second-generation antipsychotic and antidepressant drug use?

Methods

Four years of Medicaid medical and pharmacy claims data were used to determine prescription rates of antipsychotic and antidepressant medications for community dwelling, Medicaid enrolled child and adolescents with serious mental illness (SMI). The ICD-9-CM Diagnostic codes were used to identify the study sample.

Sampling Procedures

The sample included all enrollees who:

- were between the ages of 0 and 18 and were continuously Medicaid-eligible during the period FY 00–04;
- had a diagnosis of SMI as indicated by having either at least one inpatient or two outpatient claims containing appropriate ICD-9-CM codes;
- were continuously enrolled for at least 33 of 36 months after the claim date identifying them as having SMI; and
- were not enrolled in a Medicaid managed care plan or living in a nursing home (data for these individuals were not available).

Using FY 00–01 data as the baseline year enabled us to follow all subjects for a minimum of three years, through June 30, 2004.

Results

Table 1 presents demographic characteristics for our sample ($N = 4{,}792$). The mean age was 12.1 years, and 52% were male. Thirty-eight percent classified themselves as White, 27% Black, and 35% in the "Other" category (which includes Hispanic, Asian, American Indian and multiracial). Sixteen percent had a diagnosis of major psychosis, 19% bipolar disorder, and 65% major depressive disorder.

Table 1
Demographic Characteristics of Medicaid Enrolled Children and adolescents with SMI (FY00-01)

Descriptive Characteristics	*0-11 Years N= 1872*	*12-18 years N= 2920*	*All N= 4792*
Mean Age	9.1	15.1	12.1
Sex			
Male	1137 (61%)	1373 (47%)	2510 (52%)
Female	735 (39%)	1547 (53%)	2282 (48%)
Race/Ethnicity			
White	572 (31%)	1254 (43%)	1826 (38%)
Black	502 (27%)	807 (28%)	1309 (27%)
Other	798 (43%)	859 (29%)	1657 (35%)
SMI Diagnosis			
Major Psychosis	229 (12%)	549 (19%)	778 (16%)
Bipolar Dx	328 (18%)	595 (20%)	923 (19%)
MDD	1315 (70%)	1776 (61%)	3091 (65%)

The child population, aged 0–11, included 1,872 individuals with a mean age of 9.1. Sixty-one percent were male. Thirty-one percent were identified as White, 27% Black, and 43% "Other." Twelve percent had a diagnosis of major psychosis, 18% bipolar disorder, and 70% major depressive disorder.

The adolescent population, aged 12–18, included 2,920 individuals with a mean age of 15.1. Fifty-three percent were female. Forty-three percent were identified as White, 28% Black, and 29% "Other." Nineteen percent had a diagnosis of major psychosis, 20% bipolar disorder, and 61% major depressive disorder (see Table 1).

Children

Among children receiving an antypsychotic medication, major depressive disorder was the most common diagnosis among those receiving an atypical antipsychotic medication, and major psychosis was the most common diagnosis among those receiving a typical antipsychotic medication and both typical and atypical antipsychotic medications. Children in the "Other" category, when diagnosed with an SMI, were more likely to be prescribed an antipsychotic medication than Black and White children. Black children with a diagnosis of major psychosis or bipolar disorder were most likely to receive this type of medication. Given a diagnosis of major depressive disorder, children in the "Other" category were equally as likely to receive an antipsychotic medication, as White children were not to receive this medication.

Among children receiving an antidepressant medication, major depressive disorder was the most common diagnosis. Male children and those in the "Other" category were most likely to receive this type of medication. Regardless of diagnosis, White children were most likely to receive an antidepressant medication.

Adolescents

Among adolescents receiving an antipsychotic medication, major depressive disorder was the most common diagnosis among those receiving an atypical and a typical antipsychotic medication, and major psychosis was the most common diagnosis for those receiving both typical and atypical antipsychotic medications. Male adolescents were most likely to receive either an atypical antipsychotic medication or a combination of typical and atypical antipsychotic medications when diagnosed with an SMI. Females were slightly more likely to receive a typical antipsychotic medication. Among adolescents with bipolar disorder, Black children were most likely to receive this type of medication. Adolescents diagnosed with major depressive disorder were overall more likely not to receive an antipsychotic medication.

Among adolescents receiving an antidepressant medication, major depressive disorder was the most common diagnosis. When diagnosed with an SMI, female children were slightly more likely to receive older antidepressant medications or a combination of older and newer antidepressant medications while males were more likely to receive typical antidepressants. White adolescents were more likely than Black and “Other” adolescents to receive this type of medication. Regardless of diagnosis, White adolescents were most likely to receive an antidepressant medication.

Conclusion

Results show that older age and male gender predicted the prescription of newer atypical antipsychotics and older age was the only significant predictor of newer SSRI /SNRI antidepressant use. Data revealed that race does matter and that prescribing patterns were diagnosis specific and varied by race and ethnicity. For example, White children and adolescents were more likely than their Black or “Other” counterparts to receive an antidepressant medication regardless of their diagnosis. The long-term consequences of these variations in the prescription of antipsychotic and antidepressant medication are unknown and warrant further study.

Currently, few psychotropic medications have been approved for use among patients younger than 18. Both the American Psychiatric Association (APA, 2002) and the Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents (2007) do not recommend the prescription of antipsychotic or antidepressant medication for children under the age of six. Our findings show that 730 children under age 12 and 1,199 adolescents 12–18 years of age were prescribed antipsychotics. Antidepressants were prescribed for 2,520 individuals, 885 of whom were 11 years old or younger. This frequency of antipsychotic and antidepressant medications in patients younger than age 18 is of concern and has direct policy implications.

We recommend that policy makers consider restricting the use of these psychotropic medications by prior authorization or other mechanisms for all children under the age of 6 and suggest close monitoring of their prescription in individuals between 6 and 18 years of age. Future research should examine how closely prescribing patterns conform to best practice guidelines. Additionally, pharmaceutical companies should conduct clinical trials to investigate the efficacy and safety of antipsychotic and antidepressant use in children and adolescents.

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Ethnic Disparities in Special Education Placement among Children with Attention Deficit / Hyperactivity Disorder

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Introduction

This study examined racial and ethnic disparities in special education placement among children diagnosed with Attention Deficit/ Hyperactivity Disorder (ADHD). As many as half of children receiving special education services meet diagnostic criteria for ADHD (Bussing, Zima, Perwein, Belin & Widawski, 1998), including two-thirds of children in the other health impairment (OHI) category, 25% to 65% of children with an emotional disturbance (ED) placement, and 16% to 31% of children in the learning disability category (LD) (Schnoes, Reid, Wagner & Marder, 2006). Conversely, half to two-thirds of children with ADHD are served through special education, mostly through LD (Reid, Maag, Vasa & Wright, 1994).

While data on special education outcomes are limited (Donovan & Cross, 2002), children with ADHD placed in the ED category may fair worse than those in other categories. Children in ED experience worse academic outcomes than other children in special education (Landrum, Tankersley & Kaufmann, 2003), and are less likely than children in LD or OHI to be in inclusive settings, even though these settings result in better outcomes (Landrum, Katsiyannis & Archwamety, 2004).

African American students are more likely than white students to be placed in ED and mental retardation categories, and less likely to be placed in LD (Coutinho & Oswald, 2005; De Valenzuela, Copeland, Qi & Park, 2006; Skiba, Poloni-Staudinger, Gallini & Simmons, 2006). Hypotheses regarding this disparity have included genetic predisposition, cultural differences, poverty, geographic differences, and professional bias (Artilles, 2003; Donovan & Cross, 2002), though tests of these hypotheses have been hampered by limited information regarding students' behavioral and cognitive profiles. Investigators hoped, by selecting similarly impoverished children diagnosed with ADHD, to shed light on the association between ethnicity and special education placement.

Methods

The Philadelphia Medicaid behavioral health claims for calendar year 2002 were merged with special education records for all children ages 6 to 18 years in Philadelphia, PA, for calendar year 2002. The sample included all 4,852 children ages 6 to 18 years who had received at least five Medicaid-reimbursed claims for ADHD in Philadelphia, PA, for calendar year 2002.

Descriptive analyses were conducted. ANOVA for age and chi-square tests for other variables were used to estimate differences across race/ethnicity categories. Binary logistic regression was used to estimate the odds associated with each variable of any special education placement and placement in the ED category among children in special education.

Results

Table 1 describes the sample in relation to race/ethnicity. Table 2 presents the results of the logistic regression predicting special education placement. Adjusting for other variables, males were more likely to be in special education than females. Black children were less likely to receive special education services at all. Children diagnosed with adjustment disorder were also less likely to be placed than children with no diagnoses other than ADHD, while those with pervasive developmental delay were much more likely to be placed. Use of case management, wraparound, stimulants or anti-psychotics all increased the likelihood of any special education placement.

Among children who had any special education placement, older children, males and black children were more likely to be placed in the ED category. Those with a schizophrenia diagnosis were also more likely to be placed in ED, as were those who used case management, wraparound, anti-psychotics or mood stabilizers.

Table 1
Characteristics of Children Ages 6-18 Years Receiving at Least 5 Medicaid-Reimbursed Claims for ADHD in Philadelphia, PA for Calendar Year 2002 (*n* = 4,852)

	Black *(n = 3,031)*	*Latino* *(n = 383)*	*White* *(n = 820)*	*Other* *(n = 618)*	*Sig.*
Demographics					
Age [yrs, (SD)]	10.6 (2.6)	10.9 (2.7)	10.8 (2.8)	10.5 (2.7)	0.105
Male (%)	78%	75%	79%	79%	0.406
Special education placement					
Any placement	36%	39%	41%	35%	0.018
Specific learning disability	17%	25%	19%	21%	<0.001
Emotional disturbance	12%	8%	11%	7%	
Mental retardation	3%	4%	4%	3%	
Other exceptionality	4%	2%	7%	4%	
Other diagnoses received					
Any	36%	26%	32%	27%	< 0.001
Disruptive disorder	27%	14%	19%	17%	<0.001
Adjustment disorder	10%	6%	8%	7%	0.012
Affective disorder	8%	11%	14%	12%	<0.001
Schizophreniform disorder	3%	1%	2%	2%	0.053
Pervasive developmental disorder	1%	1%	3%	1%	0.004
Use of behavioral healthcare					
Case management	37%	20%	28%	18%	<0.001
Wraparound	63%	27%	42%	28%	<0.001
Inpatient stay	11%	6%	11%	8%	0.007
Partial hospitalization	17%	5%	10%	8%	<0.001
Office-based therapy	84%	96%	89%	97%	<0.001
Use of psychotropic medications					
Any medication	69%	82%	82%	83%	<0.001
Stimulants	59%	71%	69%	73%	<0.001
Anti-psychotics	13%	21%	21%	21%	<0.001
Mood stabilizer	7%	8%	14%	8%	<0.001
Number of medications					
One	40%	41%	38%	39%	<0.001
Two	18%	26%	24%	30%	
Three	7%	11%	13%	10%	
≥ Four	4%	4%	7%	4%	

Table 2
Logistic Regression Predicting Special Education Placement Among Children Ages 6-18 Years with at least 5 ADHD-Related Medicaid Reimbursed Claims In Philadelphia, PA For Calendar Year 2002

	Any special education placement (n = 4,852)		*ED placement among those in special education (n = 1,777)*	
	Odds Ratio	*95% CI*	*Odds Ratio*	*95% CI*
Demographics				
Age years)	1.10	0.95, 1.28	**1.06**	**1.01, 1.12**
Sex male)	**1.14**	**1.11, 1.17**	**1.81**	**1.34, 2.43**
Black	**0.78**	**0.66, 0.93**	**1.40**	**1.04, 1.89**
Latino	0.98	0.76, 1.26	0.86	0.52, 1.43
Other	0.86	0.68, 1.07	0.89	0.58, 1.38
Diagnoses				
Disruptive disorder	0.87	0.75, 1.02	1.16	0.89, 1.51
Adjustment disorder	**0.70**	**0.56, 0.88**	0.92	0.61, 1.38
Affective disorder	0.86	0.69, 1.08	1.13	0.76, 1.68
Schizophreniform disorder	0.75	0.50, 1.13	**4.52**	**2.13, 9.59**
Pervasive developmental disorder	**2.52**	**1.50, 4.22**	0.59	0.28, 1.24
Use of behavioral healthcare				
Case management	**1.60**	**1.38, 1.86**	**1.66**	**1.30, 2.12**
Wraparound	**1.36**	**1.17, 1.58**	**2.10**	**1.59, 2.75**
Inpatient stay	0.99	0.78, 1.25	0.91	0.62, 1.35
Partial hospitalization	0.89	0.74, 1.07	1.13	0.81, 1.58
Use of psychotropic medications				
Stimulants	**1.28**	**1.12, 1.45**	1.21	0.95, 1.53
Anti-psychotics	**1.28**	**1.08, 1.53**	**1.86**	**1.40, 2.46**
Mood stabilizer	1.14	0.90, 1.43	**1.55**	**1.09, 2.22**

Discussion

Observed disparities in ED placement are unlikely to be the result of a higher proportion of disruptive behavior problems among black children, since our analysis controlled for the presence of related disorders and the use of associated treatments, or the result of poverty or geographic variation, since our sample was restricted to Medicaid-eligible children from a single school district. Possible reasons for the observed disparity include under-treatment of black children and bias in the special education referral process.

Black children with ADHD are much less likely than their peers to receive appropriate care (Bussing, Zima & Berlin, 2003). In this study, black children were much less likely than their peers to receive medication—despite the fact that stimulants are considered the most effective treatment for ADHD (Biederman & Faraone, 2005)—and more likely to receive behavioral interventions whose effectiveness is unknown (Weisz & Jensen, 1999). Less effective treatment may result in disruptive behaviors that lead to an ED placement.

These findings might also suggest bias regarding the special education evaluation process. Children are usually referred for special education services by their teachers (Donovan & Cross, 2002), who tend to rate African American children's behavior as more disruptive than that of white children, even when independent observations suggest no difference (Elhoweris, Mutua, Alskeiks & Holloway, 2005; Epstein et al., 2005; Skiba, Michael, Nardo & Peterson, 2002). In turn, the assessment team that determines placement tends to confirm teachers' recommendations, even when contradictory evidence is present (Hosp & Reschly, 2003).

While further study is needed, these results suggest improvements necessary to both the mental health and education systems to reduce inappropriate special education placements.

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Against the Odds: Addressing Race/Ethnicity Barriers via Systems of Care

Katherine E. Grimes
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Brian Mullin

Introduction

Investigation into both health care *access* and health *status* disparities based on race and ethnicity has repeatedly confirmed that, although access to mental health services for children in the U.S. is inadequate in general (US Department of Health and Human Services [USDHHS], 1999), access to mental health services for children of color is woefully worse (USDHHS, 2001; New Freedom Commission on Mental Health, 2003). Further data on services for children receiving Medicaid suggests that they are half as likely to get treatment as children who are privately insured (Glied & Cuellar, 2003). Given the trajectory of untreated mental illness (World Health Organization, 2005), it is imperative that mental health delivery systems improve access for all children, but it is especially urgent that we even the odds for children now at-risk of getting poor quality or no care at all. The Massachusetts Mental Health Services Program for Youth (MHSPY) program, an intensively coordinated system of care built upon blended funding from Medicaid and the Massachusetts departments of Mental Health, Child Welfare, Juvenile Justice and Education (Grimes & Mullin, 2006), recently measured results of their efforts to increase access and engagement for high-need Medicaid families who might be vulnerable to racial and ethnic disparities regarding their care.

Methods

The MHSPY program is a home- and community-based clinical intervention which uses natural supports in combination with traditional health services to promote the mental health of youth who are at-risk of out-of-home placement and allow them to live in their communities. Disparities of health access and health status are addressed in the two ways. First, in order to enhance access, intensive individualized outreach is extended as a key element of the referral and enrollment process, with a senior licensed social worker spending time in person with the parent/guardian and meeting wherever the parent prefers (including the home or another location within the community) in order to get to know them as part of the referral process. Measurement of race/ethnicity, based on self-report, is collected at enrollment and compared to the prevailing community rates.

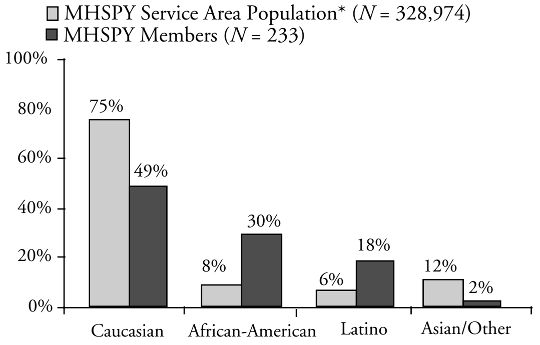
Second, health status relates to quality of services available, including the fit between providers and consumers. Upon entry to the program, MHSPY Care Managers work closely with families to identify child, family and community needs and current supports uniquely related to that family and that family's culture of origin. To gauge success with cultural sensitivity, MHSPY uses the Family Centered Behavior Scale (FCBS; Allen, Petr, & Brown,1995), which measures fidelity to system of care principles as defined by the Child and Adolescent Service System Program (CASSP). The FCBS is similar to the Wraparound Fidelity Index (Bruns, Suter, Burchard, Force, & Leverentz-Brady, 2004), in that it serves as a measure of "family friendliness." Families report the level of respect they experience in the program's approach, the treatment of the family in the Care Planning Process and in interactions with staff. Engagement is also measured by calculating the average length of enrollment in the program and monitoring the percentage of families who drop out of treatment. Data including gender, diagnosis, and referral source are used as part of outcome data analyses. These data are broken out by race/ethnicity for further identification of potential disparities.

Findings

Access. Results, based on a race/ethnicity self-report survey, indicate that more than half (51%) of the MHSPY members are children of color ($N = 233$), compared to the prevailing rate of 25% in their communities (see Figure 1).

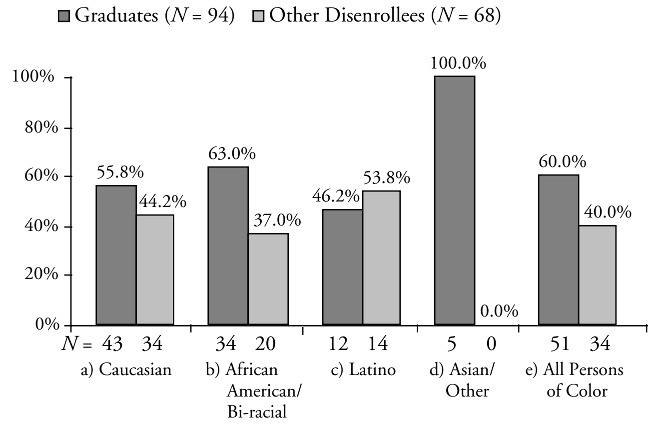
Engagement. The degree of "fit" corresponds to the level of engagement the family feels with the program and their providers. Results from the Family Centered Behavior Scale are very positive, consistent with behavior on the part of the MHSPY Care Manager being likely to support engagement. Families scored their Care Managers at 80% or higher on all 26 FCBS questions. A representative question on the survey is, "*The Care Manager respects our family's beliefs, customs, and ways that we do things in our family."* On this question, MHSPY Care Managers received a rating of "*Always*" or "*Most of the Time*" over 97% of the time. Additionally, measures of length of enrollment show families remain in the program for an average of 18 months, with a drop-out rate of only 4% over a period of eight years. Children of color remained in the program for an average of 20 months, slightly longer than the overall average length of enrollment. Similarly, children of color were more likely to graduate from MHSPY than Caucasian youth (63% vs. 56%; see Figures 1 and 2).

Figure 1
MHSPY Member Race/Ethnicity vs. Service Area Population



*Population data from the U.S. Census Bureau, Census 2000.

Figure 2
MHSPY Graduates vs. Other Disenrollees by Race/Ethnicity
March 1998 – June 2006



Note: Includes all children regardless of disenrollment reason.

Gender, referral source and diagnosis were broken down by race/ethnicity for comparison. The differences in results for gender are striking: MHSPY enrollees who are Caucasian have a 1:1 male to female ratio, while among children of color the ratio changes to 3:1 male. Examination of referral sources indicates that children of color are more likely to be referred by schools and juvenile justice in comparison to Caucasian children. In particular, Latino children appear most likely to be referred by juvenile justice, in contrast to other groups ($N = 36$). Caucasian children are more likely to be referred from the state mental health system and/or protective services ($N = 116$).

Review of diagnosis by race/ethnicity raises questions about access to state resources within "usual care." Although a higher percentage of Caucasian children are referred by protective services, a higher percentage of children of color have a primary diagnosis of Post Traumatic Stress Disorder (40%). Caucasian children are referred by the state mental health system 13% of the time vs. 11% for Latinos. However, a higher percentage of Latinos (6%) than Caucasians (4%) are diagnosed with psychosis.

Conclusion

Many families referred to MHSPY have extensive clinical records documenting prior involvement with state agencies but few actual services, due to both perceived and concrete barriers (e.g. cultural, linguistic differences, transportation, homelessness). Lack of access to *appropriate* care is highlighted by the previously noted discrepancies between diagnosis and referral source, suggesting that within usual care, children of color are often located within service settings (i.e. juvenile justice and schools) that are ill-equipped to handle their mental health needs. Based on the fact that the families in the study are twice as likely to be families of color as those in the surrounding community, access to MHSPY system of care services appears not to be limited by race/ethnicity. This finding suggests that the active efforts during the enrollment process to build relationship with the parent/guardian and reduce potential barriers posed by race/ethnicity may be helpful. Similarly, better engagement is a likely explanation for the high rates of program completion. This, in turn, creates a greater likelihood of sustainable changes in health care attitudes and health seeking behavior, thereby improving health status. In addition, deliberate efforts toward family-driven care, cultural competence, and accessible home and community-based processes may drive the low drop-out rate.

Organized systems of care, such as MHSPY, offer unique opportunities to reduce racial and ethnic barriers to health care for seriously emotionally disturbed youth and their families. By making care family-driven, and attending to individualized needs and strengths, family culture plays an integral part in how care is delivered. The level of comfort and support experienced by MHSPY families, as reported on the Family Centered Behavior Scales, undoubtedly contributes to the high program retention and the chance to make more of a difference in ultimate outcomes. There are a variety of ways that this impact on health status may be taking place; by understanding the breadth of needs and available resources, Care Managers increase their knowledge of the family's individual culture and build trust, which is likely to contribute to overall engagement.

Additionally, many MHSPY staff members, including professional parents of children with special health care needs, are themselves from diverse backgrounds and bring awareness of cultural sensitivity to their work. Diversity is a major focus of attention in staff recruitment, as well as in group training opportunities and individual supervision where open dialogue is promoted to support cultural competence. The program staff also have access to community-based colleagues and providers who have clinical expertise with a range of cultures. Access to these providers, as needed, for an individual family promotes increased cultural competence not only for the MHSPY staff, but also for other participants on that individual Care Planning Team. These activities further reduce community level risk for race or ethnicity based disparities in health care by contributing to a needed shift in the provider workforce, both in the degree to which they match the make-up of consumers, and in their overall attitudes and behavior.

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Symposium

Through a Cultural Looking Glass: Improving Services for Diverse Youth and Families

Chair
Larke N. Huang

Authors
Phillip D. Akutsu et al.
Loriena A. Yancura et al.
Yu-Wen Ying

Symposium Introduction

Larke N. Huang

Behavioral health services continue to confront challenges in providing effective care for ethnically, racially, and culturally diverse youth and their families. Structural, financial, and cultural barriers impede the pathways to effective services and positive outcomes. This is particularly the case for Asian Americans who remain an underserved or inappropriately served population in the United States (U.S. Department of Health and Human Services, 2001).

Asian Americans are one of the fastest growing populations in this country. The most recent U.S. Census showed a 48% increase for Asian Americans alone and a 72% increase for mixed-race or multiracial Asian Americans. The youth population is expected to grow by 74% between 1995 and 2015 compared to slower growth rates for other ethnic minority and White youth (Snyder & Sickmund, 1999; U.S. Bureau of the Census, 2002). Additionally, 62% of the Asian American population is foreign-born and one-third of Asian Americans are under 19 years of age. This demographic imperative requires new and innovative approaches to how we conceptualize and develop services and supports to address the needs of this emerging population of youth and families.

This symposium addressed issues along the pathway to care for Asian Americans. Key themes include: the need to challenge traditional approaches and ways of providing services and conceptualizing the issues across cultural groups; the need to deepen outreach and engagement efforts; the importance of working with families and the multi-generational family system in mental health services; the importance of building practice and policy based on the cultural values and practices of diverse communities; and the importance of a cultural lens in ensuring the meaningfulness of research with diverse groups. The three research projects in this symposium address youth and family engagement in ethnic-specific mental health services; intergenerational care-giving and service utilization; and an empirically-supported intervention for intercultural family conflict and acculturation stress.

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Predictors of Intake Attendance for Asian American Youth at an Asian-Oriented Ethnic-Specific Mental Health Program

Phillip D. Akutsu, Garyn K. Tsuru & Joyce P. Chu

Introduction

It is estimated that approximately one in every five children and adolescents in the United States are affected by a mental health problem, yet an estimated two-thirds of these youths are not receiving any mental health treatment (U.S. Department of Health and Human Services, 1999). This limitation in service use is often attributed to problems with appropriate referrals, availability/accessibility of clinical services, and long waitlists at mental health programs (Armbruster & Fallon, 1994; Benway, Hamrin, & McMahon, 2003; Kazdin & Mazurick, 1994).

High rates of pre-intake attrition or the nonattendance of intake appointments for youth populations also complicates this service delivery issue. Previous studies report rates of pre-intake attrition as high as 56% to 58% for child and adolescent populations (Benway et al., 2003; McKay, Stowe, McCadam, & Gonzales, 1998; Szapocznik et al., 1988). At initial contact, young clients or their families usually speak to a pre-intake interviewer (typically administrative staff) to seek professional assistance. Subsequently, a decision is made about whether the client is appropriate for treatment and a clinician is assigned to complete an in-person intake interview. Recent developments in culturally appropriate service delivery has led to some programs allowing clinicians to perform pre-intake interviews to facilitate greater continuity of care for reluctant client groups who pose a higher risk for intake non-attendance.

Pre-intake attrition may be a more significant problem for Asian American groups because of their consistent history of low service use and strong reluctance in seeking professional care due to stigma or shame about mental illness (Akutsu, Tsuru, & Chu, 2004; Bui & Takeuchi, 1992). A recent literature review, however, has found no studies that have investigated pre-intake attrition with Asian American children and adolescent clients.

Although race, age, gender, reported problem, and previous mental health care have been studied in the general psychology literature, no consistent relationship was identified between these variables and intake attendance (Benway et al., 2003; McKay, McCadam, & Gonzales, 1996). Only a longer period of time between first contacting a mental health provider and the scheduled intake appointment was found to predict higher intake non-attendance (Foreman & Hanna, 2000; McDonald, Brown, & Ellis, 2000). While no studies have addressed the issue of pre-intake attrition in Asian American youth, some information may be extrapolated from studies on Asian American adults. Akutsu, Tsuru, and Chu (2004), for example, found that younger age, earlier intake assignment, Asian language match with the prescreening interviewer, and assignment of the prescreening interviewer as the intake therapist helped increase intake attendance for Asian American adults.

The present study examined the relationship between certain demographic, clinical, and therapist/program factors in predicting pre-intake attrition for Asian American children and adolescent clients who sought treatment at an ethnic-specific mental health program. It was hypothesized that client match with the prescreening interviewer, assignment of the prescreening interviewer as the intake therapist, and urgency status or assignment to the earliest intake appointment would be the strongest predictors of intake attendance for Asian American youth.

Method

Participants

The participants were 179 Asian American youth (ages 12-17) who contacted an ethnic-specific mental health program in Northern California from 1988-1995 to seek clinical services. Only clients who provided valid information and were appropriate for intake assignment at this mental health provider were included in the final sample.

Variables

This study examined 14 independent variables: (1) gender; (2) age; (3) primary language of choice (English vs. Asian language); (4) previous mental health treatment; (5) number of reported problems; (6–8) type of reported problems (depression, behavioral, and family); (9) urgency of care or the need for the earliest intake appointment; (10–12) gender-, ethnic-, and Asian language-match with the prescreening interviewer; (13) continuity of care or the assignment of the prescreening interviewer as the intake therapist; and (14) ethnicity (East Asian vs. Southeast Asian). The dependent variable assessed whether the client attended the scheduled intake appointment.

Results

The average client was a 13-year old male who spoke an Asian language as his primary language (see Table 1). Few clients reported past mental health treatment and most were not determined to require urgent care or the need for earliest intake assignment. Clients reported a mean of two problems, with depression, behavioral problems, and family problems as the most commonly reported. Slightly more than half of the clients were gender-, ethnically-, and language-matched with the prescreening interview. About 38% of the clients were assigned their prescreening interviewers as their intake therapists. The intake non-attendance rate for the sample was 34%.

Table 1
Demographic, Clinical, and Program Characteristics
Between Attendees and Non-Attendees of Intake Appointments

Variables	Overall Characteristics (N = 179)	Attendance of Intake Appointment Non-Attendees (N = 61)	Attendees (N = 118)
Gender: Female	44.70%	42.60%	45.80%
Age (in years)	12.80 (3.54)	13.59 (3.38)	12.39 (3.56)*
Primary Language: English	44.70%	45.90%	44.10%
Previous Mental Health Treatment	6.10%	4.90%	6.80%
Number of Reported Problems	1.66 (0.47)	1.74 (0.44)	1.63 (0.49)
Type of Reported Problems			
Depression	33.00%	31.10%	33.90%
Behavioral	40.20%	44.30%	38.10%
Family	26.30%	32.80%	22.90%
Urgency of Care	40.20%	26.20%	47.50%**
Matching with Prescreening Interviewer			
Gender Match	46.90%	44.30%	48.30%
Asian Language Match	43.60%	36.10%	47.50%
Ethnic Match	49.70%	39.30%	55.10%‡
Prescreening Interviewer Assigned as Intake Therapist	38.00%	24.60%	44.90%**
Ethnicity: East Asian	47.50%	45.90%	48.30%

Note: Standard deviations for age and number of reported problems are presented in the parentheses in the table.
‡$p < .10$. *$p < .05$. **$p < .01$.

A series of chi square analyses and t tests were conducted to identify significant differences between attendees and non-attendees. Compared to non-attendees, attendees were younger, $t(177) = 2.17$, $p < .05$, received a higher rate of urgent care status or the need for the earliest intake appointment, $\chi^2(1, N = 179) = 7.54$, $p < .01$, and were more likely to be assigned their prescreening interviewers as their intake therapists, $\chi^2(1, N = 179) = 7.05$, $p < .01$. A marginally significant effect was also found where attendees were more likely ethnically matched with prescreening interviewers than were non-attendees, $\chi^2(1, N = 179) = 3.98$, $p = .058$.

A logistic regression analysis was performed to examine these 14 independent variables simultaneously. The regression model was found to be significant with a correct-classification rate of 68.7% in predicting intake attendance, $\chi^2(14, N = 179) = 26.94, p < .05$. Again, younger age, urgent care status or assignment to the earliest intake appointment, and continuity of care or assignment of the prescreening interviewer as the intake therapist were significantly related to increased intake attendance, $OR(1, N = 179) = 0.87, p < .05$, $OR(1, N = 179) = 2.46, p < .05$, $OR(1, N = 179) = 2.51, p < .05$, respectively (see Table 2). Ethnic match with the prescreening interviewer was also marginally significant in predicting intake attendance, $OR(1, N = 179) = 2.37, p = .082$.

Table 2
Logistic Regression Analysis for Predicting Client Attendance of Intake Appointment at an Asian-Oriented Ethnic-Specific Mental Health Program ($N = 179$)

Variable	*Odds Ratio*	*95% CI*
Gender: Female	0.89	0.40-1.99
Age (in years)	0.87*	0.78-0.97
Primary Language: English^1	0.88	0.42-1.83
Previous Mental Health Treatment^2	1.31	0.29-1.62
Number of Reported Problems	0.69	0.29-1.62
Type of Reported Problems		
Depression^3	0.99	0.39-2.51
Behavioral/Oppositional^4	0.95	0.42-2.15
Family^5	1.00	0.40-2.56
Urgency of Care^6	2.46*	1.02-5.95
Matching with Prescreening Interviewer		
Gender Match^7	1.40	0.66-3.01
Asian Language Match^8	0.90	0.38-2.16
Ethnic Match^9	2.37‡	0.90-6.25
Prescreening Interviewer Assigned as Intake Therapist^{10}	2.51*	1.18-5.32
Ethnicity: East Asian^{11}	0.71	0.31-1.65

Note: The overall correct classification of this analysis was 68.7.
$^{1\text{-}11}$ 0 = *No*, 1= *Yes*, ^{11} 1 = *Southeast Asian*, 2 = *East Asian*. $^{\ddagger}p < .10$. $^{*}p < .05$.

Discussion

The present findings examined significant predictors of intake attendance among Asian American youth—a group who typically reports low service use and high levels of reluctance in seeking mental health providers. Pre-intake attrition among the Asian American youth in this study was relatively high (34%), particularly for a clinical program that was specifically designed to serve Asian American groups. Although this figure is hardly surprising compared to past reports of intake non-attendance for youth groups in the literature, our findings suggest the importance of therapist/program factors in helping to reduce the likelihood for pre-intake attrition for Asian American children and adolescents.

Specifically, these results show that Asian American youth clients were more likely to attend intake appointments if these were scheduled soon after initial contact and if their pre-screening interviewer was assigned as the intake therapist. Younger clients also attended intake appointments at a higher rate, suggesting the possibility that older children or adolescents may be more reluctant about following through and attending the intake appointment. There was also some evidence to support that ethnic match with the prescreening interviewer increased intake attendance, suggesting the importance of shared ethnic or cultural background in facilitating a stronger patient-provider connection to improve intake attendance.

These findings suggest that therapist and programmatic factors may play a critical role in helping to reduce pre-intake attrition for young Asian American clients. Specifically, it may be clinically prudent for service providers to make organizational decisions and adjustments which would allow clinicians to perform pre-screening interviews and be assigned as intake therapists to facilitate continuity of care despite issues of financial expense in assigning clinical staff to such duties normally handled by support staff. This study supports this practice as one that may be important for working with Asian American populations who consistently report with low service use and higher rates of reluctance in seeking mental health care.

Several methodological limitations in this study suggest caution in interpreting these findings. First, this study lacked a specific length of time variable between initial contact and the scheduled intake appointment. However, the urgency of care variable assessed clinical decisions about the scheduling of intake appointments and most likely captured the significance of this time measure. Second, it will be important to study pre-intake attrition with other Asian American groups to determine whether these findings may generalize to other ethnic groups and clinical settings.

It is critical for systems of mental health care to examine multiple aspects of treatment effectiveness for improving service to Asian Americans and other ethnic minority populations. Recent studies that trumpet the advances made in clinical services for Asian Americans and ethnic minorities may be premature. Based on our findings, it is clear that service providers should consider alternative strategies to encourage Asian Americans to attend their intake appointments after they have taken the first step in contacting a service provider. Our hopes are that new strategies of service delivery to Asian Americans and other ethnic minority groups may help increase intake attendance and improve long-term outcomes in mental health care for these communities.

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Grandparents Caring for Grandchildren: Health Services Implications

Loriena A. Yancura & Barbara W. K. Yee

Introduction

Approximately 5% of the children in the United States live with their grandparents (Pebley & Rudkin, 1999). This number has grown rapidly between 1990 and 2000, with a 30% increase in children living in grandparent-headed households in the United States (Simmons & Dye, 2003). However, all grandparent-maintained households are not alike. For example, *Custodial grandparents,* take care of their grandchildren without the grandchildren's parents being present; while *Co-resident grandparents* live in the same household as their grandchildren and adult children and share responsibility for their grandchildren. In contrast, *Caretaking grandparents* do not live in the same household as their grandchildren, but take care of them on a regular basis.

Research has found that children living in grandparent-maintained households need more assistance than those in parent-maintained households (Minkler & Fuller-Thompson, 2005). Children in grandparent-maintained households are more likely to be uninsured, receive public assistance, and live in poverty than those in parent-maintained households. Sadly, grandchildren in households with custodial grandparents are the most likely to be uninsured and grandchildren living with only a custodial grandmother are the most likely to live in poverty and receive public assistance (Casper & Bryson, 1999).

Differences in the structure of grandparent-maintained households are often related to culture and ethnicity. Asian Americans (6.4%) were almost three times more likely than Whites (2.5%) to be residential grandparents, with Native Hawaiians (10%) reporting the highest rates of residential grandparenting. Although they report a higher percentage of residential grandparents, Asian Americans (20%) reported a lower percentage of custodial grandparenting than Whites (41.6%) and Native Hawaiians (38.7%) (Simmons & Dye, 2003). This could be partially explained by the high rates of intergenerational households among Asian American and Pacific Islander families (Simmons & O'Neill, 2001). Cultural roles and expectations may also influence the likelihood of custodial grandparenting (Braun, Yee, Browne, & Mokuau, 2004).

This purpose of this study was to examine specific health and service needs of custodial and caretaking grandparents in Hawai'i and to determine whether there were significant differences in these patterns of reported needs and service use by ethnic group.

Method

Participants. The data for this study were collected from 22 grandparents raising their grandchildren in the state of Hawai'i (M_{age} = 63.65 years, *Range* 52–79*)*. The majority of these grandparents were multicultural and self-identified with at least two different ethnicities. The most frequently reported ethnicities were White, Native Hawaiian, and Asian American (commonly, Japanese or Chinese American). These grandparents were divided into three groups by the authors based on the reported number of days per week and number of hours per day that they cared for their grandchildren: (a) Custodial grandparents provided care 24 hours a day, 7 days a week (N = 10); (b) Residential grandparents provided care at least 7 hours a day, 5 days a week (N = 6); and (c) Caretaking grandparents provided care less than 5 days a week or 7 hours a day (N = 6).

Procedure. The grandparent participants were recruited from public and private agencies working with custodial grandparents, children's fairs, senior fairs, a website, and word of mouth. They were interviewed individually in their homes using a structured interview protocol.

Results

A series of chi-square tests and ANOVAs showed that grandparent types significantly differed on several key demographic variables (see Table 1). Custodial grandparents were more likely to report having household incomes under $20,000 per year and caring for their grandchildren because their adult children were unavailable to care for them due to drug/substance abuse or jail/incarceration. Custodial grandparents were also more likely to be female and Native Hawaiian, but these trends were not found to be significant. Asian Americans were significantly more likely to be classified as residential or caretaking grandparents than other ethnic groups.

Table 1
Demographic Variables by Grandparent Type

	Grandparent Type				
	Custodial	*Residential*	*Caretaking*	$\chi^2(2)$	*p*
Sex: Female	89%	66%	66%	1.48	.48
Education: High School or Less	40%	50%	33%	5.59	.69
Household Income: Under $20,000 per Year	50%	0%	0%	13.09	.04
Reasons for caregiving: Children's parents on drugs or in jail	50%	0%	0%	18.41	.05
Primary Ethnicity:					
Asian American	0%	30%	30%	5.08	.08
Native Hawaiian	40%	17%	0%	3.99	.14
Age (in years)*	61.9	65.0	66.7		

Note. Age differences were tested with a one-way ANOVA, F (2, 20) = .98, *n.s.*

A series of chi-square analyses also found that grandparent types differed significantly in the reporting of grandchildren's school, psychological, and health problems and the need for services (see Table 2). Custodial grandparents were more likely to report grandchildren with learning disabilities, fear/anxiety problems, and poor grades than the other two grandparenting types. Caretaking grandparents were also more likely to report grandchildren with a physical disability. Both custodial and residential grandparents reported that they wanted more information about community services and legal rights as grandparents than caretaking grandparents. Surprisingly, none of the grandparents reported that they had foregone medical care for themselves in lieu of getting care for their grandchildren.

Table 2
Grandchildren's Health and Behaviors, Problems, and Service Use by Grandparent Type

	Grandparent Type				
	Custodial	*Residential*	*Caretaking*	$\chi^2(2)$	*p*
Discipline in School	40%	0%	17%	3.85	.14
Learning Disability	50%	0%	0%	8.30	.02
Aggression Problems	40%	0%	17%	3.85	.14
Fear/Anxiety Problems	60%	0%	33%	6.12	.04
Medical Problems	50%	33%	33%	0.91	.63
Physical Disability	0%	0%	30%	5.00	.08
Weight Problems	30%	0%	17%	1.36	.50
Poor Grades	50%	0%	17%	5.59	.06
Alcohol/Drug Use	20%	0%	0%	2.85	.24
Information about community services	90%	83%	33%	8.06	.02
Help getting/using community services	70%	50%	17%	4.26	.12
Professional Counseling	40%	17%	0%	3.99	.14
Seeking information about legal rights as grandparents	60%	33%	0%	6.54	.04

Discussion

This study was limited by its small sample size. It is often difficult to recruit grandparents who are raising grandchildren into research studies. Many grandparents do not seek help from formal service providers because they see their role as a family duty/obligation or they are not aware that they are eligible to receive such services. A larger sample of grandparents for future investigations would permit more detailed statistical analyses.

These findings are important, however, to the development of service provision for grandchildren and grandparents because service needs were found to differ according to type of grandparent-headed household. Findings also suggest that household status and grandparent involvement may be related to cultural beliefs about family relationships.

In this study, children in households maintained by custodial grandparents were at greater risk for poor outcomes than those in other types of grandparent-involved households. Children in these households had a higher percentage of physical and behavioral problems, in general, than those in other types of households. This may be related to the reasons and conditions that these children were in the care of their grandparents in the first place; many of their parents were on drugs or in jail. Unfortunately, these grandchildren may have lived most of their young lives in less than optimal home environments.

In contrast, children with caretaking grandparents reported fewer problems than the other groups. Interestingly, Asian American grandparents were most likely to be caretaking grandparents. This is consistent with the concept of collectivism, a central value to traditional Asian cultures (Yee, DeBaryshe, Yuen, Kim & McCubbin, 2006). Older Asian American women often contribute to the well-being of the family or help with co-parenting duties which might result in better outcomes for their grandchildren. One exception to this finding was that a significantly higher percentage of grandchildren with a physical disability were in the care of custodial grandparents. While caretaking grandparents can be a unique family resource, these types of grandparents may be crucial to family resiliency when their grandchildren have special needs.

The impact of residential grandparents appears to fall between the other two grandparenting types in terms of reported grandchildren's health and behavior problems. This is contrary to what would be expected if frail residential grandparents are living with their adult children because they have their own health problems. In that case, they would be providing care to grandchildren and receiving care from other household members. This type of intergenerational relationship is relatively common in Asian American families who are twice as likely as White families to provide in-home care for older relatives (Lee & Sung, 1998). However, some residential grandparents might also be similar to custodial grandparents in that their adult children may not be providing adequate care or a consistent presence in the lives of these children. Thus, residential grandparents in our sample might be a heterogeneous group. Some evidence for this speculation is provided by the relatively high percentage of residential grandparents who requested information about community services and their legal rights as grandparents. Among residential grandparents, Asian Americans reported fewer grandchildren's problems and less service use.

Policy Implications

There is a critical need to examine how family roles beyond the common parent-child relationship impact child outcomes. The extended family may serve to provide support and/or generate burden for Asian American, Pacific Islander, and ethnic minority communities. Grandparents have a pivotal role in facilitating family resiliency and often step into the parenting role when their adult children cannot or will not assume it. Social policy must be flexible to respond to the various ways in which families support younger and older family members. For example, in Hawai'i, many grandparents may assume custodial roles for their grandchildren when their adult children are abusing drugs or jailed. However, current laws may prevent anyone but legal guardians from enrolling children in schools or accessing medical care. A parent may be reluctant to give up legal guardianship of their children, even on a temporary basis, and these legal barriers could be problematic for grandparents who seek to enroll their grandchildren in school or provide permission for medical services. This research illustrates the increasing importance of grandparents in family decision-making, childhood outcomes, and family resiliency within intergenerational families.

Another important social policy issue in this research is the complex role that culture may have on the enactment of grandparent and family roles and the impact on such changing roles on grandparent caregivers and short-term and long-term outcomes for grandchildren. Traditional grandparent, parent, and family roles may be influenced by beliefs from the home culture and by level of acculturation. Social policies must be able to respond to diverse family scenarios to promote positive child outcomes and family resiliency.

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Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF)[1]

Yu-Wen Ying

Introduction

At the dawn of the 21st century, 12% of the American population consists of immigrants, most of whom migrated from Latin America and Asia (U.S. Census Bureau, 2003). Consequently, the majority of Latino and Asian American children are growing up in immigrant households throughout the United States (Zhou, 1997). Due to differential rates of acculturation between the generations and significant variation between the traditional values held by immigrant parents and the majority American values increasingly embraced by their children (Ho, 1993; Sandoval, & De La Roza, 1986), intergenerational conflict is a common occurrence in these immigrant families (Sluzki, 1979). Research has shown these intergenerational conflicts can have negative mental health consequences for both immigrant parents and their children (Buki, Ma, Strom, & Strom, 2003; Ying & Han, 2006; Ying & Han, 2007).

In spite of this literature, very few interventions are available to ameliorate this problem. As ethnic minorities tend to underutilize traditional mental health services due to cultural barriers (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), community-based, non-traditional mental health specific services are needed to assist these immigrant families. Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF) is a culturally-sensitive intervention program that aims to ameliorate intergenerational conflict in immigrant families. The current paper provides an overview of the SITIF program and presents initial empirical evidence of its effectiveness with Chinese American parents.

Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF) Program

SITIF is a community-based educational intervention program that aims to strengthen the intergenerational relationship between immigrant parents and their school-age children. Based on Bandura's social learning theory (1977), parents are taught to affectively empathize with their child's perspective, to cognitively understand variation in the ethnic and American cultures and its impact on their child's development, values, and their intergenerational relationship, and to develop effective behavioral parenting skills, all of which can promote intergenerational communication and intimacy and help to reduce family conflict. Additionally, parents are introduced to methods that may be used to cope with the stresses of parenting and recent migration.

SITIF Program's Effectiveness with Chinese American Immigrant Parents

The current study assesses the use of the SITIF program with middle- and working-class Chinese American immigrant parents. Four major research questions were posed:

1. Do parents effectively engage with the SITIF program?
2. Do parents demonstrate objective mastery of the SITIF curriculum?
3. Does the SITIF program enhance effective parenting practices and strengthen the intergenerational relationship based on subjective parental report?; and,
4. Is there a positive association between objective mastery and subjective evaluation of the SITIF course?

Furthermore, across all four of these study questions, the significance of socioeconomic status was assessed for the immigrant parents.

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[1] *A longer, complete version of this paper appears in Ying, Y. (2007). Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF): Testing a culturally-sensitive, community-based intervention with Chinese American parents.* Journal of Immigrant and Refugee Studies, 5*(2), 67-90.*

Method

Participants and Procedure

From a community sample, 30 Chinese American immigrant parents were recruited to participate in this evaluation study (83.3% female; Mean age = 41.97 years, *SD* = 7.08). Of these participants, 16 were middle-class, Mandarin-speaking parents and 14 were working-class, Cantonese-speaking parents. The middle-class parents were recruited at a presentation on intergenerational conflict held at a Mandarin Chinese-language school, while the working-class parents were recruited by flyers in Chinatown, radio announcements on a Cantonese Chinese community radio talk show, and word-of-mouth in the community. The SITIF classes were held in neighborhoods with a high Chinese concentration and consisted of two-hour weekly meetings over the course of eight weeks. Detailed outlines for each class were distributed to the parents and weekly homework was assigned to assist in parental mastery of the SITIF class content.

Measures

Engagement with the SITIF Program was measured by recording weekly attendance and the completion of homework assignments by the instructor. Over the course of the eight-week intervention, seven sets of homework exercises were assigned by the instructor.

Objective Mastery of the SITIF Curriculum was assessed in four domains: Awareness/knowledge of cultural difference; rationale/objective of parenting skills; implementation of parenting skills; and coping with stress. To assess Awareness/Knowledge, five questions were posed to the participants (e.g., "*Why does intergenerational/intercultural gap occur in immigrant families?*"). Rationale/Objective of Behavioral Parenting Skills was assessed with seven questions posed to the parents (e.g., "*What is the rationale/objective of 'Showing Understanding'?*"). Implementation of Behavioral Parenting Skills assessed the procedure for implementing the seven parenting skills that were listed in the above domain (e.g., "*How do you 'Show Understanding' to your child?*"). Coping with Stress was assessed by the following single question: "*How may parents reduce their stress level?*" Responses to the above questions were coded as 1, *correct*, or, 0, *incorrect* and summed for each of the four areas.

Subjective Evaluation of the SITIF Program's Effectiveness was assessed using both close- and open-ended questions on the SITIF Evaluation Form. The effectiveness score for the close-ended questions was derived from responses to seven statements (e.g., "*This course increased my ability to parent my child.*") that were rated on a five-point Likert-type scale, with higher scores indicating greater agreement. Furthermore, parents were asked to respond to five open-ended questions to assess the SITIF Program's effectiveness. A sample item for these open-ended questions was "*As a result of taking this course, how did you change in the way you parent?*" These qualitative responses were reviewed and coded by two masters-level social work students, of which one was a native speaker of Mandarin and the other a native speaker of Cantonese. The overall rate of inter-rater reliability for these two reviewers was 91.8%.

Results

A series of *t*-tests were performed to identify significant differences between the parent groups in the following areas.

Engagement with the SITIF Program

Middle-class parents (*M* = 7.50 sessions, *SD* = .82) attended more weekly sessions than working-class parents (*M* = 6.36 sessions, *SD* = 1.08), *t*(28) = 3.29, *p* = .003. They also completed more homework assignments (*M* = 6.19, *SD* = 1.22) than working-class parents (*M* = 3.36; *SD* = 2.84), *t*(28) = 3.45, *p* = .003. While middle-class parents evidenced more overall engagement, working-class parents still attended 80% of the intervention program, and their lower rate of homework completion may be partially due to their limited education.

Objective Mastery of the SITIF Curriculum

With regard to Awareness/Knowledge, middle-class parents (*M* = 4.44, *SD* = .51, 88.8%) provided more correct responses than working-class parents (*M* = 3.79, SD = 1.05, 75.8%), *t*(28) = 2.11, *p* = .05. With regard to mastery of Rationale/Objective of Behavioral Parenting Skills, middle-class parents (*M* = 5.06, *SD* = 1.29, 72.29%) also provided more correct responses than working-class parents (*M* = 3.57, *SD* = 1.45, 51%), *t*(28) = 2.98, *p* = .006. In terms of mastery of Implementation of Behavioral Parenting Skills, the two parent groups did not significantly differ. However, middle-class parents (*M* = 4.50, *SD* = 1.37, 64.28%) provided a higher number of correct responses than working-class parents (*M* = 3.64, *SD* = 2.10, 52.00%). With regard to Coping with Stress, the parent groups were not significantly different and reported a high percentage (93.33%) of the correct answer.

Subjective Evaluation of the SITIF Program's Effectiveness

Both middle-class and working-class parents rated the SITIF program as extremely effective in enhancing their parenting skills and strengthening their intergenerational relationship, reporting a mean score of 4.73 (*SD* = .34) on a five-point scale. In terms of their subjective evaluation of the effectiveness of the SITIF program, 93.3% reported a personal change; 90% reported a change in parenting method, 90% identified one helpful aspect of the SITIF program, and 96.7% reported a positive change in their intergenerational relationship with their child (i.e., describing it as more open, more egalitarian, and more intimate than before involvement in the SITIF intervention).

Discussion

While these findings are preliminary—based on a single application of the intervention with 30 participants—overall, the study offers promising results for the SITIF program and points to the critical need for furthering testing of SITIF with other immigrant parent groups. Notably, parents expressed very high subjective satisfaction with this training program, and demonstrated a high level of objective mastery with the SITIF curriculum. However, middle-class parents did outperform working class parents in some areas in the program. In light of both groups' performance on the parenting skills items, the SITIF program has now been expanded to 10 two-hour weekly sessions to allow for more in-class practice.

Despite these positive results, future studies should empirically test the SITIF program's effectiveness with non-Chinese immigrant populations. For example, Latino Americans who comprise the largest immigrant group in the United States and report with high numbers of school-aged children may prove to be a good match for future studies using the SITIF program. In spite of these limitations concerning generalizability to other immigrant groups, this study makes a significant contribution to the literature in how to assist immigrant families by demonstrating the utility of the newly developed SITIF program in enhancing parenting effectiveness and intergenerational intimacy among a diverse group of Chinese American immigrant parents.

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