

Middletown Children's Mental Health Planning Grant Coalition

Community Research Seminar, Spring 2009

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INTRODUCTION

This study is predicated upon research that shows early treatment of mental health problems can improve children's life prospects, reducing their chances of experiencing school discipline, substance abuse, educational failure, and incarceration. Many children who need mental health services do not receive them. This study helps to cast light on the obstacles preventing children from using mental health services by gathering the perspectives of parents in Middletown, Connecticut.

Four Wesleyan students collaborated with a coalition consisting of the Middletown Public Schools, the Ministerial Alliance, and the Middlesex Collaborative for Children's Mental Health. These organizations came together in January 2008 to request a grant from the Connecticut Health Foundation to develop a plan to reduce the number of at-risk children ages 6 to 14 from entering the most intensive mental health treatment and/or the juvenile justice system through a secondary prevention system of early identification, assessment and interventions. This study seeks to assist the coalition by providing insight into parent perceptions of mental health and mental health services. Specifically, it attempts to collect parents' attitudes toward mental health services, their awareness of those services, and their reports of external barriers to obtaining those services.

The coalition recognizes that demographic factors influence the way that families experience mental health care. To take this into account, the present study examines the effects of parent's race, income, and education level on a family's willingness and ability to obtain services for children. Previous studies have found that both mental illness and African American race increases chances for eventual intensive mental health treatment

and/or incarceration. They have also found that African Americans are less likely than members of other racial groups to receive mental health services.

By identifying the barriers preventing various groups from accessing services, we hope to help the coalition to develop a plan that will improve the psychological wellbeing of all Middletown's children and potentially reduce the number of young people experiencing school suspension or expulsion and in the long run entering the juvenile justice system.

LITERATURE REVIEW

The following research review explores previous studies that uncovered patterns in behaviors and attitudes in relation to mental health services. First, we will explore the state of the juvenile justice system and its relationship to mental health services. Next, we review the literature that highlights barriers that parents face when trying to obtain mental health services. Finally, we look at past research that demonstrates how parents' level of awareness about getting mental health services and their attitudes towards those services affect service utilization.

Juvenile Justice System

Although there are numerous factors that lead children to contact with the juvenile justice system, research shows that both race and mental illnesses are independent factors that may lead to an increased chance of eventual incarceration. Within the juvenile justice system, almost two-thirds of youth meet criteria for one or more mental health disorder. Minority youth (specifically African American) are overrepresented within all the stages of the U.S. juvenile justice system. Our study does not specifically focus on the juvenile justice system but instead aims at finding trends and indentifying gaps in providing services to Middletown residents, so they do not end up in that system.

Barriers to Children's Mental Health Services

Mental health professionals are not treating youth as often as is needed, even outside the juvenile justice system. Pihlakoski et al. report that less than one-third of

children who need treatment received any kind in the previous year (2004: 974). This gap between need and service use could be explained by structural barriers, a lack of awareness of mental health issues and services, and/or negative attitudes towards services. All these factors can prevent those who are in need of services from obtaining them. For example, Owens et al. (2002) cite a lack of availability of providers, long waiting lists, lack of insurance, inadequate insurance coverage, inability to pay for services, transportation problems, and inconvenient services as primary obstacles to receiving services. Structural barriers have also been found to differ by race of the family. NAMI (2005) reports that African Americans are at a significant socioeconomic disadvantage with respect to accessing medical and mental health care.

Barriers associated with parental perceptions of service need for their child include such things as the inability of parents to identify a child's mental health problem, their denial of the severity of the problem, or their belief that the problem can be handled without treatment. Since parents are most in control of what services their child receives, it is important that these barriers are eliminated. Much of the literature stresses the important role that parents play in seeking services when they have identified issues. For instance, Zwaanswijk et al. found that 28% of adolescents whose parent identified them as having a mental health issue had sought help in the previous year, as opposed to only 23% of adolescents whose problem was identified by others (2003:692).

Another barrier is parental beliefs about the different causes of their children's problems and these may be tied to cultural differences. Yeh et al. explain that differential beliefs about the causes of mental health problems may account for differences in service utilization between racial groups (2004). Parents of African American, Asian/Pacific

Islander, and Latino youths are less likely than parents of non-Hispanic Whites to report biopsychosocial causes (e.g., physical causes, personality, relational issues, family issues, and trauma) for problematic behavior and more likely to report sociological causes (e.g., American culture and prejudice) (2004:609-10). Disagreement between a family and provider about the causes of problem behavior can increase noncompliance and treatment dropout on the part of families (2004:611-612).

Still other barriers are related to perceptions of mental health services, such as lack of trust in, or negative experience with, mental health providers, and a fear of stigma related to receiving help. Racial patterns have also been observed in the degree of trust in, or negative experience with, mental health providers. NAMI (2005) reports that African Americans tend to rely on family, religious, and social communities for emotional support, rather than seeking mental health services. They argue that cultural biases against both mental and health professionals, due to prior experiences with misdiagnoses, inadequate treatment, and lack of cultural understanding, may prevent many African Americans from accessing care. Fear of stigma and labeling related to utilizing services may also prevent children from receiving the help they need; NAMI (2005) reports that mental illness is frequently stigmatized in the African American community. Evans (1999) specifically considers parental fears of labeling with respect to their children receiving mental health services through schools. He reports that some parents worry about issues such as confidentiality because they fear outcomes such as labeling due to school-based mental health treatment.

Yet, other literature points to the importance of schools for the detection of children's mental health issues. Leaf et al. emphasize the importance of school-based

mental health services because schools present a unique opportunity for the early detection of psychiatric disorders and the mobilization of resources for the support of children with serious emotional and behavioral problems (1999: 895).

From the literature emerge numerous issues surrounding parent's awareness, attitudes, and perceived barriers that our study explored in relation to Middletown residents and the services offered. We sought to understand the services in Middletown in two ways: the barriers parents cite within Middletown—structural, awareness related or attitudinal—and, within these categories, to explore whether trends emerge when considering demographic factors such as race, income, and education.

METHODOLOGY

The purpose of this study is to assess parent perceptions of mental health and the services available for the treatment of the related behavioral, emotional, and social issues. We distributed a survey to parents of 6 to 14 year old children currently enrolled in Middletown public schools. We focused on the parents of public school students in this age range because our community partner is interested in designing a school-based system of care that will reach students at-risk for developing mental health disorders before these disorders cause serious problems. The survey was administered to two groups of parents. The first group was randomly selected and contacted by mail. The second, intended to boost the number of African American respondents, was approached through local churches.

Mail Survey

We conducted a mail survey for two main reasons: (1) Given the sensitive nature of the subject, a mail survey allows for anonymity and confidentiality of participants. We believed that participants would be more likely to not only respond, but to respond more honestly and accurately to questions about issues that tend to be extremely personal; (2) A mail survey enabled us to contact many more potential participants in a shorter timeframe than in-person or phone interviews would have. Given our concerns about participant willingness to discuss this subject matter, we felt that it was necessary to contact a high number of families in order to obtain a participant base large enough to establish statistically significant findings.

Our goal was to create a survey that flowed naturally and logically led through the different areas we hoped to cover: barriers, awareness, and attitudes. We started out with a number of simple demographic questions, followed by hypothetical situations that involved other children's mental health, and then transitioned to asking the parents about their own feelings, their child's mental health, and their experiences with services.

Once the first draft of our survey was completed, we brought it to a number of social workers and pastors in the community to get their input and advice and pretested the resulting instrument, making changes where needed. For a copy of the final survey instrument, see Appendix A.

Enclosed in the mailed packet was a cover letter (see appendix B) that explained the study, asked for recipient's participation, and informed them that participating in the survey would enter them into a raffle to win a \$250.00 gift certificate to Stop and Shop, a survey, a return envelope for the survey, and a separate post card on which participants included their names and contact information so that they could be entered in the raffle without their identifying information being attached to their completed survey (see appendix C). The post cards also had an option for participants to check if they would be interested in participating in a follow-up interview or focus group to talk more about the subject.

Sampling

The intent of our study was to collect a random, representative sample of parents of children, ages 6-14, enrolled in Middletown public schools. To obtain this sample, we narrowed down a list of all children in the Middletown Public School system (N = 5,177) to include only families with listed addresses and children in the target age range (N= 3,175). In order to prevent guardians from being contacted multiple times, we removed the names of all but one child--the child whose name came first in alphabetical order-- from each household (N = 2,265). We then organized the list alphabetically and deleted every other name, followed by every tenth name, leaving a final random sample of 1,020 children whose parents were mailed a survey.

Response Rate

Of the 1,020 surveys distributed, 271 returned with usable data. One survey was returned to sender. Twelve surveys were returned after the cutoff response date. African American parents were slightly underrepresented: they made up 10.3% of our total response pool, despite the fact that 19.0% of children in Middletown schools are African American. Because of this, we decided to distribute additional surveys in African American churches in Middletown as a way to bolster African American responses and make them more representative of the distribution of African Americans in Middletown public schools. Including the church responses, our total overall African American population was 17.7% of all responses, much closer to the goal of 19.0%.

Survey Distribution in Churches

Our focus on the African American community is in part because researchers in the field think this population is disproportionately affected by service gaps and unmet need for mental health services; indeed, this was one of the questions our community partners were most interested in exploring. We hoped that additional information from the church surveys would provide insight into perceptions of mental health and mental health services among African American parents.

Four pastors in the Ministerial Alliance allowed us to distribute surveys during their Sunday services. While the survey remained the same for this additional sample, we had a slightly altered cover letter (see appendix D). We were advised by one of the pastors that incentive should not be included in the church survey, as he did not want to introduce money into the community, and instead wanted people to participate because they care about the community and the future of the children. We received 28 usable surveys from the churches, the results of which were analyzed separately from the random sample.

Data Analysis

All of the survey responses were coded and entered into a Statistical Package for the Social Sciences, or SPSS, spreadsheet. Using SPSS, we were able to further analyze the participants' results using both descriptive and predictive statistical measures. We used Chi-Square tests to test the strength of relationships between participants' demographic characteristics and their responses to survey questions.

In analyzing the church data, we remained cognizant that the sample was drawn completely from a churchgoing population, and we first compared the African American mail responses to the African American church responses to establish that they were statistically similar, using two-tailed t-tests, Pearson chi-square tests, and Fisher's exact tests. These tests confirmed no patterned differences between African American in the mail survey and those in the church surveys.

The only caveat to this was in the responses for the questions about the services that respondents would recommend to a friend if their child showed signs of mental health issues compared to where they themselves would seek services if their own child developed signs of mental health issues. There were statistical differences in the responses to both of these questions between the mail and church survey ($p < .05$). Specifically, 58.3% of church respondents as opposed to 18.5% of African American mail respondents said that they would recommend religious leader consultation to a friend. Similarly, 58.3% of church respondents as opposed to 17.9% of African American mail respondents said that they would seek religious leader consultation for their own children. These results make sense in light of the fact that we are comparing the average parent of a Middletown public school child (not necessarily religious) to parents within the faith-based community. It is only natural that parents who attend church would be more likely to rely on religious leaders for help and advice. But, interestingly, as we discuss below, the children of church respondents, like those of mail survey respondents, did not actually receive mental health services from pastors.

Given the similarity of the data between the two samples, we only report findings from the added church data when it alters findings generated solely from the mail data.

Limitations

While we are confident in the value of our findings, we note four weaknesses in our study design and implementation that may have biased our results.

First, the fact that participation in our study required the ability to read English meant that we were not able to obtain responses from non-English speaking or illiterate parents. Ideally, we would have been able to offer the study in a range of languages, but financial and time constraints prevented us from being able to guard against this potentially biasing limitation.

Second, time constraints prevented us from including as many local perspectives in the process of constructing the survey instrument as we would have liked. Two pastors and two social workers edited the survey before it was administered, but there was not enough time to have discussions with families, teachers, therapists, or other involved parties about what questions we should be asking. We particularly regret that we did not have the opportunity to ask more parents in the community whether the survey asked the correct questions in a way that elicited valuable responses. We designed our survey based primarily on the literature and our own intuition, and we hope that future studies will have the resources necessary to include the perspectives of more people of color and people outside of academia.

Third, we acknowledge the complications that accompany the use of any self-report study. Our findings hinge upon the presumed honesty and accuracy of responses. Given the sensitive nature of the subject matter, however, it is possible that respondents may have been less than truthful about certain sensitive questions. It is possible in a study

of this nature that some participants have fallen into the trap of the self-presentation bias, meaning they answered the way they thought they ought to respond, rather than the way they actually felt.

Finally, we acknowledge the technical imperfection of our survey instrument. Two flaws in the instrument surfaced when we began analyzing data. In one item, we failed to include a “non-applicable” category in asking whether participants would seek mental health care for their children at the advice of a pastor.

The second flaw was that there appeared to be some confusion among respondents when filling out questions 12 and 13, which had to do with which service providers people had received services from and who had recommended that they seek services. A significantly greater number of survey respondents answered these questions than had responded yes to question 10: “has your child ever received behavioral, emotional, or social health services?” This seems to indicate that some respondents were checking service providers and referral figures for question 12 and 13 when they had actually seen them for reasons other than behavioral, emotional, or social health issues (e.g., a child’s annual check-up at doctor). To counter this potential respondent error in interpretation, we only considered responses to questions 12 and 13 that had come from respondents who had responded yes to question 10 (i.e., we ran a layered cross-tab with question 10). In taking this measure, we believe that, if anything, we have erred on the side of caution and thus may have lost statistical significance in some of findings by greatly reducing the sample size.

Our results should be reviewed with these imperfections in mind. Yet, despite our study's limitations, we believe that it accurately presents important information that has been previously unexplored.

RESULTS AND DISCUSSION

Our study targeted three main areas of interest: attitudes about mental health and mental health services, awareness of existing services and of mental health problems in general, and utilization of services. We looked at the ways that various demographic characteristics affected parental notions of mental health as a way to explain what it is that parents are thinking about the behavioral, social, and emotional health of their children and to see if there were any structural differences that affected popular beliefs about mental health.

General Results

Overarchingly, parents were found to recognize signs of mental health issues and know when to seek help for their children. Furthermore, the more problem behaviors a parent identified a child as having, the more likely the parent was to believe that these behaviors were indicative of their child having a mental health issue ($p < .05$) (see Table 1)¹ and needing services ($p < .05$). In general, parents followed up on their children's behavior; identifying more signs is correlated to a child having received mental health services ($p < .05$) (see Table 1 and Graph 1).

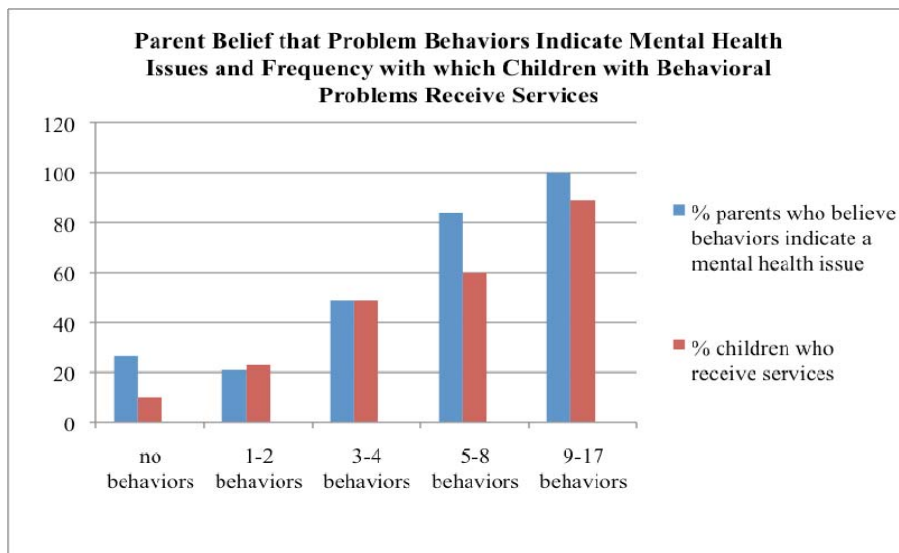
¹ Results are considered "statistically significant" if it is unlikely that they have occurred by chance. A p-value is the probability of finding the same result by chance. Our study accepts p-values less than .05 as statistically significant. This means that if we call a finding "significant," there is less than a 5% chance that it happened by chance. We also report non-statistically significant results when there is a dramatic difference between groups and results.

| Table 1 | | | | |
|---|---|-------------|---------------------|-------------|
| Parent Belief that Problem Behaviors Indicate Mental Health Issues and Frequency with which Children with Behavioral Problems Receive Services | | | | |
| | Belief Behaviors Indicate Mental Health Issues* | | Received Services** | |
| | Yes | No | Yes | No |
| No Behaviors | 4 26.7% | 11 73.3% | 9 10.1% | 80 89.0% |
| 1-2 Behaviors | 18 20.9% | 68 79.1% | 20 23.0% | 67 77.0% |
| 3-4 Behaviors | 21 48.8% | 22 51.2% | 21 48.8% | 22 51.2% |
| 5-8 Behaviors | 21 84.0% | 4 16.0% | 15 60.0% | 10 40.0% |
| 9-17 Behaviors | 8 100% | 0 0.0% | 8 88.9% | 1 11.1% |

Table 1. Parents who identified their child as having a greater number of behaviors associated those behaviors with the existence of mental health issues. Similarly, an increase in the number of behaviors was correlated to the frequency of a child receiving mental health services.

* $\chi^2(4, N = 177) = 47.415, p < .05$.

** $\chi^2(4, N = 253) = 52.666, p < .05$.



Race

Significant racial differences in rates of diagnosis and service use were not apparent in Middletown, which is surprising given previous findings that African Americans are more likely than Caucasians to be diagnosed with mental health problems and less likely to be treated. About 15% of the children of both Caucasian and African American parents were found to have been diagnosed with a social, emotional, or behavioral issue. Children of African American and children of Caucasian parents diagnosed with mental health problems used services at 21.4% and 27.8% respectively, a difference that was not statistically significant.

Despite similar rates of diagnosis and service use, African American and Caucasian families reported experiencing mental health services differently. Race influenced the way that children were referred to services, and parents of different races tended to prefer different types of services and to obtain different types of services for their children.

Family advice was a more important impetus for seeking mental health care among African American families. African Americans who had sought services for a child were much more likely than Caucasians to have been advised to do so by a relative (33.3% compared to 5.8%) ($p < .05$). Likewise, African Americans were more likely to report that they would advise another family member to seek services for a child in need (27.3% compared to 7.2%) ($p < .05$).

Parent intuition and non-medical, daily life authorities may also have been more important sources of diagnosis for African Americans. When asked to identify the person

who had advised them to seek services for their child, 83.3% of African Americans, as compared to 59.6% of Caucasians, responded “No one, I decided myself.” Furthermore, African American parents whose children had received services were twice as likely as Caucasian parents to have sought those services after having been urged to do so by a school counselor (33.0% compared to 15.4% or teacher (50.0% compared to 25.0%). However, our sample size was such that none of these trends were statistically significant.

Race also influenced the type of services that parents turned to for help. Caucasians tended to prefer to consult formal and medical authorities more often, whereas African Americans indicated a desire to reach out to more familiar sources of support. For instance, Caucasian parents were far more likely than African American parents to indicate that they would recommend that a friend consult a doctor (84.7% compared to 63.0%) ($p < .05$) or to say that they would take their own child to see a doctor (85.0% compared to 57.1 %) ($p < .05$). These parents appear to have been true to their word. When parents who had sought services for their children were asked to specify what types of services they had used, Caucasians were more likely than African Americans to have consulted a doctor (57.4% compared to 33.3%).

Caucasians were also significantly more likely than African Americans to recommend that a friend seek support from a school counselor (62.7% compared to 28.6%) and to indicate that they would consult a school counselor if their own child developed a problem ($p < .05$). For their own children, 84.6% of Caucasian parents, as compared to 40.7% of African American parents, responded that they would have their child talk to a school counselor. In reality, the children of Caucasians who had sought services may have been likely than their African American counterparts to have used

school counselors, although this trend does not reach statistical significance. With the church surveys included, 44.4% of Caucasians, compared to 26.7% of African Americans, had children who had visited counselors

In keeping with their patterns of service seeking, African Americans were more likely to keep problems in the family. A larger proportion of surveyed African Americans recommended that their friends address a problem themselves than Caucasians (37.0% compared to 28.6%) ($p < .05$) and indicated that they had addressed problems themselves rather than seek out services in the past (66.7% compared to 16.7%) ($p < .05$). They were also more likely to recommend going to a family member for help than Caucasians (29.6% compared to 13.8%) ($p < .05$), and appear to have been more likely to have gone to a family member for help in the past, although this trend did not reach statistical significance (33.3% compared to 14.8%) .

Non-medical authorities suggest themselves as more likely sources of support for African American families. African Americans were significantly more likely than Caucasians to say that they would consult a peer specialist at Connecticut Behavioral Health Partnership (25.0% to 6.7%) or a religious leader (17.9% compared to 10.4%) if their child were to develop mental health problems in the future ($p < .05$), although these differences weren't marked in practice.²

Income and Education

Our next two variables, income and education, are generally linked to “social class” (as both indicators and predictors of class); we found both correlated to differences

² In actual practice only one parent, an African American, had consulted a peer specialist (16.7%) ($p < .05$). We were not able to find statistically significant figures on actual use of religious leaders. These results did not include the Church surveys.

in our respondents' responses. We believe that there may be some interaction between the two variables and suggest that further study should be done on the ways that these interact with regard to mental health attitudes, awareness, and barriers. In the present study, however, we analyze them separately as if each has its own explanatory power.

Income

Table 2 details how we divided survey respondent families into five income levels: Below Poverty, Lower Middle, Middle, Upper Middle, and Upper. This breakdown is based on income data found from the US Census Bureau which states that the average household inflation protected income in 2009 is \$60,397 and the United States Department of Health and Human Services, which states that federal poverty level for a four person family is \$22,050.

| Table 2 | | | | |
|--------------------------------|----------------------|----------------------|-----------------------|---------------------|
| Family Income Breakdown | | | | |
| Less than \$20,000 | \$20,001 to \$50,000 | \$50,001 to \$80,000 | \$80,000 to \$100,000 | More than \$100,001 |
| Below Poverty (BP) | Lower Middle (LM) | Middle (M) | Upper Middle (UM) | Upper (U) |

BP Families reported that their children have significantly more signs of mental health issues ($p < .05$); 36.7% of BP families reported that their children displayed five or more signs, while for all higher income levels, the percentages were far lower: LM (13.0%), M (10.0%), UM (10.0%), and U (7.5%). It is unclear from the data whether children below the poverty level are more likely to exhibit signs of mental health issues or whether parents of these children are more able to identify these signs, and more likely to report them. Future research into the subject will be helpful to disentangle cause and effect.

BP families also appear more likely to have been “diagnosed” with mental health issues: 32.3% of children from BP families have been diagnosed as opposed to only 12.3-14.3% of children from families in all other income levels. Yet, contrary to findings in much of the literature that the children of lower-income families receive fewer services, family income had no effect on the probability that a child who had been diagnosed with a mental health problem would receive treatment. Regardless of family income level, children who had received a diagnosis used services at high rates that were statistically indistinguishable (100% BP, 85.7% LM, 100% M, 100% UP, and 88.9% U). Noteworthy differences become apparent between income levels in the types of services parents say they would recommend to others, in the types of services they predict they would use themselves if their child were to develop mental health issues, in the actual services they chose to use, and in who referred them to the services they ended up using.

For instance, BP families were significantly less likely to recommend to a friend that they take their child to see a doctor to deal with a mental health issues than wealthier families ($p < .05$). Only 63.3% of people below the poverty level indicated that they

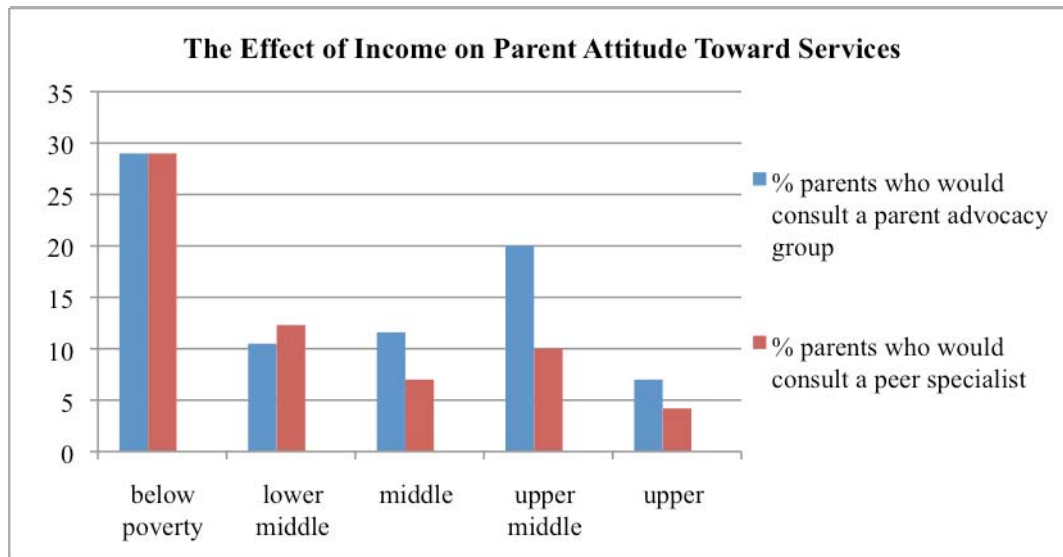
would recommend seeing a doctor, whereas in all other income levels, 78.3% or more of respondents said that they would recommend seeing a doctor. In contrast, when asked what services parents would access should their child develop a mental health issue, BP families were significantly more likely to say that they would take their child to a parent advocacy group and that they would take their child to a peer specialist at CT Behavioral Health Partnership ($p < .05$).

| Table 3 | | |
|--|--|---|
| Income Differences in Parental Attitudes Toward Service | | |
| | Would take their child to a parent advocacy group* | Would take their child to a peer specialist at CT Behavioral Health Partnership** |
| Below Poverty | 9 29.0% | 9 29.0% |
| Lower-Middle | 6 10.5% | 7 12.3% |
| Middle | 5 11.6% | 3 7.0% |
| Upper-Middle | 12 20.0% | 6 10.0% |
| Upper | 5 7.0% | 3 4.2% |

Table 2. BP Parents were more likely to think about parent advocacy groups and peer specialists as viable options should their child develop a problem in the future.

* $\chi^2 (4, N = 262) = 11.155, p < .05$.

** $\chi^2 (4, N = 262) = 14.838, p < .05$.



Actual service use in the past also revealed differences between BP families and higher-income groups. BP families were more likely to have used parent advocacy groups, in line with (and actually exceeding) the predictions of BP families that they would use parent advocacy groups should their child develop mental health issues (43.8% of BP families as opposed to 6.7% of LM families and 0% of all other income groups) ($p < .05$). However, contrary to the prediction that they would consult a peer specialist, BP families (and all other income levels) were not found to have consulted a peer specialist. Also virtually no families, regardless of income level, indicated that they had consulted a religious leader. This finding holds, even after the data from the church survey were combined with that of the mail survey, indicating that even African American faith-based communities do not generally rely on their pastors for actual mental health services.

At the other end of the income spectrum, UMC and UC families were noticeably more likely to have consulted a doctor (60.0% and 61.5% of cases, while BP, LM, and M only consulted a doctor in 43.8%, 53.3%, and 38.5% of the cases respectively). Further differences in past service use were found across income groups, but these showed no clear pattern. For

example, noticeably higher rates of therapist use were found for BP (87.5%), UMC (80.0%), and U (84.6%) families compared to LM (66.7%) and M (53.8%) families. It is possible that this decrease in therapist service use found for LM and M may be due to the fact that they fall in a gap where they are not eligible for such services to be provided for them free of charge and yet cannot quite afford to pay for them themselves, but we lacked the qualitative data to explore this.

Overall, our data signify a gap between the services that people below and above the poverty level are using. BP families generally seek services from less formal providers such as parent advocacy groups, while UM and U families apparently seek more formal services such as doctors.

Finally, there were differences by income level in who referred parents to the services they ended up using. M, UM, and U families were much more likely than BP and LM families to say that they had decided to seek services of their own volition (72.7-80.0% vs. 43.8-46.7%). BP families were more likely to have been referred to services by a social worker (43.8% vs. 0.0-7.7% for all other income levels) or by a friend (31.2% vs. 0.0-7.7% for all other income levels). These findings may indicate a trend of higher income families feeling more confident in their own ability to judge the necessity of seeking services for their children, while lower income families depend more on the judgment of outside sources. Regardless of income level, virtually no families indicated that a religious leader had referred them to services. This finding holds, even after the data from the church survey was combined with that of the mail survey, indicating that even African American faith-based communities do not generally rely on their pastors to refer them to services.

Despite a difference in services used by families above and below the poverty line, we found no evidence suggesting that economic differences accounted for differences in ability to access mental health services. Respondents did not frequently indicate that obstacles commonly cited in previous studies, such as lack of insurance and lack of transportation, prevented them from seeking mental health services for their children. Of potential interest is that two people (20% of church respondents who provided responses on this topic), as opposed to no mail respondents, indicated not being able to afford services, not having time to seek services, and not knowing where to get services as barriers. Yet for all three of these barriers the number of people that expressed them as issues was so small (two people) that the results were not statistically significant. In light of this trend, we recommend that future studies look further into these three potential barriers.

Furthermore, although no respondents in the mail survey indicated that they “could not afford” services, there seemed to be many differences amongst the parents and guardians that correlated to their income level. It could be that these differences are due to factors that we had no data on (e.g. insurance coverage or access to medical providers.) These results, we suggest, show trends of what services seem to be most *inviting* and *accessible* to parents based on their income level.

Education

Differences in rate of diagnosis were found across education levels although these did not achieve the level of statistical significance. Having a household education level of graduate studies appears to be associated with a trend towards decreased levels of child diagnosis (8.5%, as compared to 19.0% and 17.6%, in the lower education levels).

Overall, children of highly educated parents are less often referred to, and have less contact with, mental health services. Explanations for these differences may be that there are fewer incidences of mental health issues in higher educated families or that there is simply less identification of problems amongst the children of higher educated parents.

Contrary to the conventional assumption that the children of less educated parents receive fewer services, parent education level had no effect on the probability that a child who had been diagnosed with a mental health problem would receive treatment. Regardless of parent education level, children who had received a diagnosis used services at high rates that were statistically indistinguishable (87.5% high school, 96.6% college, 100% graduate).

Where some differences become apparent between income levels, however, are in the types of services parents say they would recommend to others, in the actual services they used, and in who referred them to the services they ended up using. For instance, graduate educated families were more likely than either college or high school educated families to recommend to a friend that they speak with their child's teacher (62.3% graduate vs. 38.3% college and 46.3% high school) ($p < .05$) or consult a school counselor (72.1% graduate vs. 56.1% college and 59.3% high school). Similarly, graduate and college educated families were more likely than high school educated families to recommend consulting a religious leader (18.0% graduate and 15.6% college vs. 2.4% high school). Together these findings suggest a tendency for higher educated families to be more likely to recommend consulting authorities when a child seems to need mental health services as opposed to friends or family.

Actual service use rates among education groups reveal two contrasting trends in seeking medical services (neither of which, however, achieved statistical significance): parents with a high school education indicated that they would seek help from their child's doctor 83.3% of the time, as compared to only 46.3% among parents with a college level education and 50.0% among parents with a graduate school level of education, but high school educated families are less likely than college or graduate educated families to have consulted a therapist (58.3% high school vs. 75.9% college and 87.5% graduate). School authority service use, in contrast, show no patterns by income. Interestingly, despite being more likely to indicate that they would they would recommend that a friend consult school authority figures such as teachers and counselors, graduate educated families did not utilize these services more often than lower educated families.

We found marked differences by income in the pathways families used to arrive at the need for services (though, again, these did not achieve statistical significance). High school educated families appear more likely than college and graduate educated families to have taken the advice of a teacher (41.7% as opposed to 21.1% and 12.5%) or a friend (25.0% vs. 11.5% and 0.0%) in seeking services. High school and college-educated families appear more likely than graduate educated families to taken the advice of a family member (16.7% and 15.4% vs. 0.0%). College and graduate educated families appear more likely than high school educated families to have said that they had decided to seek services on their on volition (63.5% and 75.0% vs. 41.7%). Overall, these findings seem similar to those of income, suggesting a trend of higher educated families feeling more confident in their own ability to judge the necessity of seeking

services for their children, while lower educated families seem to depend more on the judgment of outside sources.

Part of the difference in who families sought out for services may be explained by lower levels of satisfaction with *past* services among those with lower incomes. Households with a high school diploma or less were satisfied 77.8% of the time, whereas the other education levels were satisfied 91.5% and 93.3% of the time. Numerous issues with barriers, attitudes towards the services, and problems with providers could explain the trend of less satisfaction with lower education level. It may be that this gap in satisfaction is caused by education level itself. Parents of lower education levels may not understand the medical processes or the jargon that mental health professionals use in treatment. The potential for lower educated families to feel lost and confused throughout the process of seeking mental health services might have the effect of making them feel less satisfied with the services they receive.

Gender

Gender differences were significant in terms of diagnosis, with boys being diagnosed with mental health issues twice as often as girls (21.0% vs. 10.6%). Respondents' attitudes toward seeking services for their child also differed based upon the gender of the child, but less drastically. Parents of boys were slightly more likely to seek services recommended by school authorities than parents of girls (100% vs. 90.8%) ($p < .05$). Likewise, boys' parents said they would seek services if a religious leader

suggested them in 80.3% of the cases, whereas only 70.8% of girls' parents responded in the same way. In all, it seems that parents of boys may be slightly more open to getting services for their children than parents of girls. We speculate these differences may be attributable to societal expectations of gendered behavior traits, but we did not have enough data to explore this possibility.

CONCLUSION AND RECOMMENDATIONS

Our results firmly contradict findings elsewhere that African American children are more likely to be diagnosed, but less likely to receive treatment for, a mental health disorder. It was not race, but lower income and, perhaps, lower levels of parent education, that were associated with increased rates of diagnosis. Neither race nor income nor education had an effect on overall service use or the likelihood that a child would obtain treatment after receiving a diagnosis. Our results also contradict popular assumptions that lower-income parents are less likely to identify potential mental health issues. Furthermore, parents did not explicitly identify any structural barriers, such as lack of insurance or transportation, to obtaining services for their children.

While our survey responses indicated the absence of sweeping differences in service use and diagnosis, they did reveal differences in the pathways parents took to obtaining services, their preferences for different types of services, and the types of services actually used. African American families were more likely to get advice from family and friends. Families below the poverty line reported more willingness to use Peer Specialists and Family Advocacy services, although the actual use was extremely low. Caucasian families and families with higher income usually sought out services from their family doctor. Knowledge of these differences in pathways, preferences, and types of services used can help mental health advocates decide where to focus certain services depending on the demographic characteristics of their target population.

In addition to this knowledge of differences, our study produced two troubling findings. First, the parents of children below the poverty line indicated that their children displayed a striking number of problem behaviors. Future studies should examine

whether the conditions produced by poverty really do increase mental illness among children, or whether another factor accounts for this difference in parent reporting. Second, parents with a high school diploma or less may have been less satisfied with the mental health services their children received. This finding was not statistically significant, but may merit further consideration.

Future studies should also examine reasons behind the higher rate of diagnosis among lower-class families. Are children from higher class families less likely to receive a diagnosis when they need one? Are children from lower class families more likely to be incorrectly labeled as psychologically unwell? Could children from lower class families actually suffer from increased levels of mental illness? In the first case, Middletown mental health advocates should focus their efforts on increasing outreach efforts among upper-class families. Spreading awareness among parents, doctors, and school workers should increase levels of child diagnosis among the higher classes and ensure that more children get the help they need. In the second case, the general population should be made aware of the cultural tendency to pathologize lower-class children. This would help parents, teachers, social workers, and others to resist the impulse to let class influence their judgment of a child's psychological wellbeing. In the third case, mental health providers should make sure that their services effectively meet the needs of lower class children, and Middletown organizations should give serious consideration to the conditions that are psychologically harming children living below the poverty line.

Regardless of the results of future studies, increasing school awareness of mental health signs and issues may be one important venue towards treating a maximum of

children. Across the board, parents were generally willing to seek services on advice of school. This trust in the school as an appropriate and accepted place to recommend services transcends race, income, and education level. About 95% of the parents responding reported they would be willing to seek services for their child should the school suggest that they could benefit from doing so.

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APPENDICES

Appendix A

Middletown Children’s Services Survey

This survey is designed to take around 10 minutes. Please answer the following questions to the best of your ability. This is an anonymous survey and all information sent to us will be confidential. We will not be able to link your returned post card with your survey responses. If you do not wish to answer a question, you may skip it and you may feel free to stop at any time. Thank you for your time in helping us to improve the health of Middletown’s children.

Please fill out this survey for the child whose name appeared on the envelope.

1) Please indicate your child’s age, grade level, and gender below:

Age _____

Grade Level _____

Gender (circle one): Female Male

2) What is the name of your child’s current school? (check the name)

Elementary Schools:

- | | |
|-----------------------|---------------|
| _____ Bielefield | _____ Moody |
| _____ Farm Hill | _____ Snow |
| _____ Lawrence School | _____ Spencer |
| _____ Macdonough | _____ Wesley |

Middle Schools:

- _____ Keigwin
- _____ Woodrow Wilson Middle School

3) If your **friend’s** child showed signs of behavioral, emotional, or social health issues, who would you suggest that the parents consult? (check all that apply)

- | | |
|--------------------------------------|---------------------------------------|
| _____ No one – they should not worry | _____ Family member |
| _____ Address the problem themselves | _____ Hospital |
| _____ Care Coordination Services | _____ Intensive In-home Child and |
| _____ Child’s doctor | _____ Adolescent Psychiatric Services |
| _____ DCF Voluntary Services | _____ School counselor |
| _____ EMPS | _____ Law enforcement |

- _____ Parent Advocacy Group
- _____ Peer specialist at CT Behavioral Health Partnership
- _____ Religious leader
- _____ School teacher

- _____ Social worker
- _____ Therapist/ psychologist
- _____ Other (indicate which)
- _____

4) If the school came to you suggesting that ***your*** child could benefit from behavioral and mental health services, would you seek them out for your child? (circle one)

YES

NO

5) If your Pastor or religious leader came to you suggesting that ***your*** child could benefit from behavioral, emotional, or social health services, would you seek them out for your child? (circle one)

YES

NO

6) If your child developed a behavioral, emotional, or social health issue in the ***future***, where would you go for help? (check all that apply)

- _____ No one – I would not worry
- _____ Address the problem myself
- _____ Care Coordination Services
- _____ Child’s doctor
- _____ DCF Voluntary Services
- _____ EMPS
- _____ Family member
- _____ Hospital
- _____ Intensive In-home Child and Adolescent Psychiatric Services
- _____ School counselor

- _____ Law enforcement
- _____ Parent Advocacy Group
- _____ Peer specialist at CT Behavioral Health Partnership
- _____ Religious leader
- _____ School teacher
- _____ Social worker
- _____ Therapist/ psychologist
- _____ Other (indicate which)
- _____

7) Has your child shown signs of the following in the last year? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Tires easily, has little energy | <input type="checkbox"/> New interest in being with you |
| <input type="checkbox"/> Fidgety, unable to sit still | <input type="checkbox"/> Feels he or she is bad |
| <input type="checkbox"/> Has trouble with teacher | <input type="checkbox"/> Takes Unnecessary risks |
| <input type="checkbox"/> Distracted/ daydreams easily | <input type="checkbox"/> Acts younger than children his or her own age |
| <input type="checkbox"/> Is afraid of new situations | <input type="checkbox"/> Does not listen to rules |
| <input type="checkbox"/> Feels sad, unhappy | <input type="checkbox"/> Doesn't understand others' feelings |
| <input type="checkbox"/> Is irritable, angry | <input type="checkbox"/> Teases others |
| <input type="checkbox"/> Less interested in friends | <input type="checkbox"/> Steals things he/she doesn't own |
| <input type="checkbox"/> Fights with other children | <input type="checkbox"/> Refuses to share |
| <input type="checkbox"/> Absent from school | <input type="checkbox"/> No, my child shows none of these behaviors |
| <input type="checkbox"/> School grades dropping | |
| <input type="checkbox"/> Has trouble sleeping | |
| <input type="checkbox"/> Worries a lot | |

8) If you checked any signs in question 7, do you think these signs were caused by behavioral, emotional, or social health issues? (circle one)

YES

NO

9) Has your child ever been diagnosed with behavioral, emotional, or social health issues? (circle one)

YES

NO

10) Has your child ever received behavioral, emotional, or social health services? (circle one)

YES

NO

11) Which of the following services have you heard of before? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Autism Society of CT (ASCONN) | <input type="checkbox"/> Middlesex Hospital Behavioral Health Center |
| <input type="checkbox"/> Children's Home of Cromwell | <input type="checkbox"/> Middletown Youth Services Bureau |
| <input type="checkbox"/> CT Behavioral Health Partnership | <input type="checkbox"/> Odd-Fellows Playhouse |
| <input type="checkbox"/> DCF Voluntary Services | <input type="checkbox"/> Out Patient Therapy Services |
| <input type="checkbox"/> Emergency Mobile Psychiatric Service (EMPS, formerly known as IMPACT) | <input type="checkbox"/> Parent Advocacy Groups: FAVOR, Families United |
| <input type="checkbox"/> Extended Day Treatment (EDT) | <input type="checkbox"/> Parent Aid |
| <input type="checkbox"/> Family Advocacy (Mid. Hosp.) | <input type="checkbox"/> Partial Hospitalization Program (PHP) |
| <input type="checkbox"/> Green Street Art Center | <input type="checkbox"/> Rushford Center |
| <input type="checkbox"/> In-home Services: Intensive In-home Child and Psychiatric Service (IICAPS), Care Coordination, Functional Family Therapy (FFT) | <input type="checkbox"/> School based health clinics |
| <input type="checkbox"/> Maternal Health and Child | <input type="checkbox"/> TMCA - Kids Corner |
| | <input type="checkbox"/> None |

12) From which of the following types of providers has your child ever received services? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Law enforcement |
| <input type="checkbox"/> I addressed the problem myself | <input type="checkbox"/> Parent Advocacy Group |
| <input type="checkbox"/> Care Coordination Services | <input type="checkbox"/> Peer specialist at CT Behavioral Health Partnership |
| <input type="checkbox"/> Child's doctor | <input type="checkbox"/> Religious leader |
| <input type="checkbox"/> DCF Voluntary Services | <input type="checkbox"/> School teacher |
| <input type="checkbox"/> EMPS | <input type="checkbox"/> Social worker |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Therapist/ psychologist |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Other (indicate which) |
| <input type="checkbox"/> Intensive In-home Child and Adolescent Psychiatric Services | <input type="checkbox"/> _____ |
| <input type="checkbox"/> School counselor | |

_____ None

18) What is **your** age? (check age group that applies)

_____ 19 and under

_____ 35-39

_____ 20-24

_____ 40-44

_____ 25-29

_____ 45-50

_____ 30-34

_____ 51 and over

19) How many adults over 18 are living in your household? _____

20) What is **your** race? (check one that applies)

_____ Caucasian

_____ Mixed Race (indicate)

_____ Hispanic

_____ Native American

_____ Other (indicate)

_____ African-American

_____ Asian or Pacific Islander

21) What is your **child's** race? (check one that applies)

_____ Caucasian

_____ Mixed Race (indicate)

_____ Hispanic

_____ Native American

_____ Other (indicate) -

_____ African-American

_____ Asian or Pacific Islander

22) What is your total household income? (check income group that applies)

_____ Under \$10,000

_____ \$60,001-70,000

_____ \$10,000-20,000

_____ \$70,001-80,000

_____ \$20,001-30,000

_____ \$80,001-90,000

_____ \$30,001-40,000

_____ \$90,001-100,000

_____ \$40,001-50,000

_____ \$100,001 and above

_____ \$50,001-60,000

23) What is the highest education level in your household? (check one that applies)

_____ Middle school or less

_____ High school diploma/

_____ Some high school

GED

_____ Some college

_____ Associates degree

_____ College degree

_____ Masters degree

_____ Graduate degree

Thank you so much for taking the time to complete our survey!

Appendix B

Return Postcard

Thank you for participating in our survey! For a chance to win a \$250 gift card to Stop and Shop, please respond by April 1st. Please fill out your name, address, and phone number in the space provided and mail this pre-stamped post card back at the same time as you return your completed survey. There will be no way to link your survey results with your identifying information.

Name: _____

Mailing address: _____

Phone number: _____

Would you be interested in participating in a follow-up interview to help us learn how to better help Middletown's children? _____ Yes _____ No

March 2, 2009

Dear Parent/Guardian,

We are writing to ask for your help with a project being conducted by a group of Wesleyan students on behalf of the Middletown Children's Mental Health Planning Grant Coalition. This coalition includes the Middletown public schools, the Ministerial Alliance, and community health providers, all of whom have united to create a strategy to improve the social, emotional, and behavioral health of Middletown's children. To better serve the needs of the children in our community a team of Wesleyan students are inviting parents to participate in a survey to help gather data to best support a plan to accomplish this goal.

We would appreciate it if you could fill out the short survey that is enclosed. **All participants will be automatically entered in a raffle to win a \$250 gift card to Stop and Shop.** It should take approximately 10 minutes to complete. You do not need to put your name on the survey. The survey is anonymous and the information collected from it will not be linked to you in any way.

Please return the completed survey in the pre-stamped and addressed envelope. In addition, please mail the separate stamped post card (so your survey can't be linked to your name) to let us know that you've completed the survey. When we receive the card your name will automatically be included in the drawing for the raffle prize of \$250 to Stop and Shop.

If you have any questions about this project, you can call Professor Rob Rosenthal, the supervising faculty member for the project, at (860) 685-2943 or email him at RRosenthal@wesleyan.edu.

Thank you for your time, and for helping us with this important project.

Sincerely,

Lauren Barth
Philip Benjamin
Jena Gordon
Alexis Sturdy

Appendix D

April 19, 2009

Dear Parent/Guardian,

We are writing to ask for your help with a project being conducted by a group of Wesleyan students on behalf of the Middletown Children's Mental Health Planning Grant Coalition. This coalition includes the Middletown public schools, the Ministerial Alliance, and community health providers, all of whom have united to create a strategy to improve the social, emotional, and behavioral health of Middletown's children. To better serve the needs of the children in our community a team of Wesleyan students are inviting parents to participate in a survey to help gather data to best support a plan to accomplish this goal.

We would appreciate it if you could fill out the short survey that is attached. It should take approximately 10-15 minutes to complete. You do not need to put your name on the survey. The survey is anonymous and the information collected from it will not be linked to you in any way. If you have already received this survey in the mail and have completed and sent it back then please do not fill it out again.

Feel free to tear off this front informational page if you would like, but please return the rest of the survey with numbered pages.

If you have any questions about this project, you can call Professor Rob Rosenthal, the supervising faculty member for the project, at (860) 685-2943 or email him at RRosenthal@wesleyan.edu.

Thank you for your time, and for helping us with this important research.

Sincerely,

Lauren Barth
Philip Benjamin
Jena Gordon
Alexis Sturdy

APPENDIX E

EXTENDED LITERATURE REVIEW

Mental Illness, Race, and the Juvenile Justice System

There is significant previous literature that considers the relationship between mental illness and the juvenile justice system. Grisso poses three potential reasons for the high prevalence of mental disorders in the juvenile criminal justice setting: clinical, socio-legal, and inter-systemic (2008:148). Clinically, mental health issues that increase aggression also increase the odds of coming into contact with the criminal justice system (2008:150). Socio-legally, new and more stringent laws require that offending youth are more likely to go to jail. Inter-systemically, during the 1990s there was a reduction in youth mental health services offered, which has resulted in the criminal justice system filling this gap (2008:151). Given all of this, it is not surprising that Grisso reports that almost two-thirds of youth involved in the juvenile justice system meet the criteria for one or more mental health disorders (2008:143).

Focusing more on race, Piquero examines the fact that youth of color are overrepresented at every stage of the U.S. juvenile justice system. He discusses two hypotheses to explain such overrepresentation: differential involvement and differential selection (2008:66-7). The differential involvement hypothesis posits that youth of color commit more crimes and are thus more likely to come into contact with the law. The differential selection hypothesis posits that there are differences in the severity and level of policing between neighborhoods that are predominantly White and those that are communities of color. Piquero cites evidence showing that Blacks receive more severe sentences than Whites for the same crime and that they are more likely to get transferred to a criminal court regardless of the crime. Furthermore, Black youth are

more likely than Whites to be formerly charged in juvenile court and to be sentenced to out-of-home placement, even when referred for the same offense (Piquero 2008:62).

Race and mental illness are seen as linked by The National Alliance on Mental Illness (NAMI). NAMI (2005) discusses a variety of social circumstances that affect African Americans disproportionately, such as homelessness, children's placement in foster care, and exposure to violence, all of which have all been found to increase vulnerability to mental illness.

It is clear that both race and mental illness raise the likelihood an individual will have contact with the juvenile justice system. Besides changing the way that the legal system treats youth of color, one potential way to reduce the number of youth of color in the juvenile justice system is to attempt to treat those who have mental health issues before they get to the point of entering the system. Pihlakoski et al. examine the use and need of mental health services for emotional and behavioral problems among preadolescents. They state that a large discrepancy exists between the number of children with psychiatric disorders and those receiving services, such that less than one-third of children who need treatment received any kind of mental health care in the previous year (2004: 974).

Barriers to Children's Mental Health Services

Owens et al. discuss three types of barriers to children's mental health services (2002:732). First are structural barriers, which include a lack of availability of providers, long waiting lists, lack of insurance, inadequate insurance coverage, inability to pay for services, transportation problems, and inconvenient services. Second are barriers related to perceptions of mental health problems, such as the inability of parents, teachers, and medical care providers to identify

children's need for mental health services, denial of the severity of a mental health problem, and a belief that the problem can be handled without treatment. Third are barriers related to perceptions of mental health services, such as lack of trust in, or negative experience with, mental health providers and a fear of stigma related to receiving help. Owens et al.'s study show that more than 35% of parents reported a barrier to mental health services. Some of the barriers parents reported were: 21% of parents reported structural barriers, 23% of parents reported barriers related to perceptions of mental health problems, and 26% reported barriers related to perceptions of mental health services (2002:735). We will consider each of these types of barriers and the literature that discusses them in the following three sections.

Structural Barriers

One common structural barrier that impairs parents' ability to utilize mental health services for their children is the inability to pay for services. Heneghan et al. (1997) found that 60% of parents report that inadequate funding or financial means are barriers for families accessing mental health services. Several researchers have found that a family's inability to pay for services is often due to lack of insurance or inadequate insurance coverage. For instance, Heneghan et al. found that 26% of families reported a lack of adequate health insurance to obtain school or community health services (1997:329). Likewise, Flisher (1997) found unmet need for mental health services to be associated with being on public assistance and/or lack of health insurance. Finally, Glied et al. report that 15% of American children are uninsured and that low-income families are uninsured at an elevated rate of 25% (1997:169). In addition to being the least insured, low-income children have the highest rate of psychiatric disorder and mental health

impairment. One-third of children in families on Medicaid meet the criteria for a serious emotional disorder (1997:170).

Finally, parents' opportunity to utilize services for their children has also been found to vary by race. Kataoka et al. (2002) report that 75% of children who had mental health problems did not receive services; 80% of blacks, 82% of Hispanics, and 72% of whites who had mental health issues also had unmet need (2002:1551). NAMI (2005) reports that African Americans are at a significant socioeconomic disadvantage with respect to accessing medical and mental health care. In 2001, 20.2% of African Americans were uninsured.

Two final and related structural barriers that are frequently identified in the literature are inconvenient services and transportation problems. Flisher et al. found common parental perceptions that services are inconvenient and take too much time, and that often transportation is a limiting factor (1997:1152-3). Heneghan et al. also state that 75% of parents believe that transportation (getting to appropriate community referrals of school linked services) is a major problem (1997:329).

Barriers Related to Perceptions of Mental Health Problems: Awareness

Slade looks at racial differences between African American, Hispanic, and White non-Hispanic parent perception of child need for mental health services following school suspension or expulsion. His results showed that 38% of African American children and 20% of Hispanic children, as compared to 12.3% of White children, had been suspended or expelled from school

by age 14. Additionally, he found that first-time suspension or expulsion is positively associated with the pre-existence of serious behavior problems, as reported by the children's mothers (2004:80-1). Slade goes on to conclude that first-time school suspension or expulsion is shown to positively affect service use and parent-reported service need among White non-Hispanic children, but had little to no effect for African American and Hispanic children (2004:75).

Finally Zwaanswijk et al. studied the factors associated with adolescent mental health service need and utilization. At age eight, two important indicators for future mental health service referral in the study were found to be parent-reported behavior problems and teacher's perception of need (2003:692). Both of these findings emphasize the importance of parents' and teachers' ability to identify children's need for services. The study reports that only 23% of adolescents who were identified as having mental health problems had sought help in the previous year as opposed to 28% of adolescents whose parents identified them as having mental health issues(2003:692). Zwaanswijk et al. emphasize the importance of parents role in initiating mental health service use because adolescents with emotional and behavioral problems are less likely than parents to seek services and less able to initiate service use (2003:697). At the same time as he explains that parent awareness is important, he also stresses the value of educating adolescents concerning the nature of mental health problems, how and where to get help, and the commonality of various problems. He believes this increased personal awareness can help adolescents to self-identify problems in cases where adult figures such as parents and teachers fail to do so for them (2003:699).

As Zwaanskijk et al. explain in their study, not only is parental ability to identify problems and seek services for their children important, but also the school system (i.e., teachers and clinicians that work in them) must be able to do so. Leaf et al. emphasize the importance of

school-based mental health services because schools present a unique opportunity for the early detection of psychiatric disorders and the mobilization of resources for the support of children with serious emotional and behavioral problems (1999:895). Evans also looks at mental health service delivery through schools, which he claims plays an important role in identifying early mental health issues related to problem behaviors. He asserts that schools are second only to parents in shaping children's development, which makes them an ideal place for treatment. He also states that schools are more effective than other sites for mental health service delivery because clinicians have access to teachers, can readily observe social interactions, can manipulate important contingencies, and can verify facts pertaining to important events (1999:169).

In this way, both parents and schools have been shown to play important roles identifying children's need for mental health services. However, Evans discusses how as a result of these overlapping roles parents and schools can sometimes come into conflict. He notes that one of the criticisms of school-based mental health treatment is that it can be viewed as an infringement on parental rights by the education system. For instance, parents are notified that their children are being treated and then have to object, as opposed to actively seeking mental health services for their children, which can be viewed as the school taking too active of a role (1999:174).

As opposed to parental objections, Heneghan et al. discuss lack of parental awareness as a common barrier encountered by schools in providing mental health services for children. Principals and mental health program directors reported two key barriers schools face in providing services: 33% reported limited parental awareness about the importance of preventative mental health care and 19% reported resistance to the belief that schools are responsible for providing or coordinating health services for children (1997:329). Similar to

what school personnel reported, 47% of parents in this study believe that lack of parental awareness about the importance of preventative health care for their children is an impediment (1997:329). Heneghan et al. conclude that schools are ideal locations to deliver health services (including mental health) for children because they have the potential to circumvent many of the economic and logistic barriers that often impede many children from receiving help from other sources of mental health services.

Regardless of whose job it is to identify mental health problems and seek services for children, Stiffman et al. emphasize the important point that adolescents do not typically seek mental health services on their own, even if they are able to recognize problem behaviors in self reports. Instead, they are usually directed to services by parents, teachers, juvenile justice authorities, or other adults (2000:142). Stiffman et al. studied the role that mental health providers play in moderating the gap between adolescents' need for services and their receipt of them. The authors refer to providers from four types of service sectors as "gateway" providers: primary health, child welfare, juvenile justice, and education (2000:142). Providers from these sectors often have the first contact with youth (after parents), identify problems, provide some immediate services, and refer the youth to any additional needed services. Stiffman et al. point out that for poor youth, services for mental health problems are often limited to those provided from the public sectors (e.g., child welfare and juvenile justice). The authors conclude that gateway providers may be more likely to identify youths' problems and refer them to appropriate services when they have extensive knowledge of community resources and knowledge of brief and accurate screening devices.

Another barrier related to perceptions of mental health problems are parents' beliefs about the different causes of problems and their ability to be handled without treatment. Yeh et al.

explain that differential beliefs about the causes of mental health problems may account for differences in service utilization between different racial groups (2004). Parents of African American, Asian/Pacific Islander American, and Latino youths are less likely than parents of non-Hispanic Whites to report biopsychosocial causes (e.g., physical causes, personality, relational issues, family issues, and trauma) for problem behavior and more likely to report sociological causes (e.g., American culture and prejudice) (2004:609-10). Disagreement between a family and provider about the causes of problem behavior increases noncompliance and treatment dropout on the part of families (2004:611-612).

Barriers Related to Perception of Mental Health Services: Attitudes

Racial patterns have also been observed in the degree of trust in, or negative experience with, mental health providers. NAMI (2005) reports that African Americans tend to rely on family, religious, and social communities for emotional support, rather than seeking mental health services. They claim that cultural biases against mental and health professionals due to prior experiences with misdiagnoses, inadequate treatment, and lack of cultural understanding, may prevent many African Americans from accessing care. Some of this lack of cultural understanding experienced by African Americans may be due in part to the fact that only 2% of psychiatrists, 2% of psychologists, and 4% of social workers are African American.

Another related barrier is fear of stigma and labeling related to utilizing services. NAMI (2005) reports that mental illness is frequently stigmatized and misunderstood in the African American community. As a result, Wilson (2001) stresses the importance of services being available that are free from racism or stereotypical labeling for African Americans. African

Americans need places to feel safe in expressing their problems without fear of labeling or other inappropriate responses. Evans (1999) specifically considers parental fears of labeling with respect to their children receiving mental health services through schools. He reports that some parents worry about issues such as confidentiality with respect to their children because they fear outcomes such as labeling if their children were to receive treatment in school. Evans presents data which shows that although 52% of parents with children in clinic-based mental health services doubted confidentiality of school-based mental health services, 93% of parents with children in school-based care said that confidentiality was not a problem (1999:168). In this way, it seems that if quality services that are culturally sensitive can be provided, issues of labeling and fear of stigmatization may be overcome.

Suggestions for Change in the Future

After discussing the three types of barriers to children's mental health services, Owens et al. (2002) conclude that in order to increase children's access to these services, researchers and policymakers should not only seek to eliminate structural barriers, but also attempt to change parent's negative perceptions about mental health problems and barriers.

NAMI (2005) makes several suggestions for innovations of existing programs and the implementation of new ones that may lead to an increase in African Americans' use of mental health services. First, programs in African American communities sponsored by already existing and well-respected institutions such as churches and local community groups can lead to an increase in the awareness of mental health issues, resources available for their treatment, and decrease stigma related to them. Second, programs that improve enrollment rates in health care

providers can lead to an increase in mental health care due to improved overall health coverage in the African American community. Third, encouragement from the community to join mental health professions can increase the number of African American mental health providers and thereby increase social and cultural sensitivity among the provider community. Fourth, increasing overall sensitivity to African American cultural differences, such as differences in medication metabolization rates, unique views of mental illness, and propensity towards experiencing certain mental illnesses, can improve African Americans' treatment experiences and increase utilization of mental health services.