CENTER FOR HUMAN SERVICES RESEARCH
UNIVERSITY AT ALBANY State University of New York

Research Brief
Cultural Equity in the Orange County System of Care
June 2012

Introduction

This research brief was prepared for the Cultural Equity Task Force (CET) for discussion on June 12, 2012. The purpose of this report is to inform the CET's continuing cultural equity efforts by providing information on the racial and ethnic distribution of youth in the Orange County System of Care (OCSOC), and families' perceptions of the cultural competence of their service providers.

A description of youth in the OCSOC is followed by a discussion of racial and ethnic disparities in the children's mental health system. The experiences of local, OCSOC youth and families are discussed within this larger context.

Findings are presented from the local evaluation of the OCSOC. Please refer to p. 7 for a description of the evaluation and data sources.

How Race and Hispanic Origin are Defined

The EDIF collects race and Hispanic origin the same way the U.S. Census[1] does, as two separate variables. The two questions are:

> **What is the child's race?** (select all that apply): ❍White ❍Black or African American ❍American Indian or Alaska Native ❍Asian Indian ❍Chinese ❍Filipino ❍Japanese ❍Korean ❍Vietnamese ❍Other Asian (specify) ❍Native Hawaiian ❍Guamanian or Chamorro ❍Samoan ❍Other Pacific Islander (specify).
>
> **Is child of Hispanic, Latino, or Spanish origin?** (select one answer): ❍No ❍Yes, Mexican American or Chicano ❍Yes, Puerto Rican ❍Yes, Cuban ❍Yes, another Hispanic, Latino, or Spanish origin (specify).

Analysts are then able to report single and multiple race categories as well as whether a youth is also of Hispanic, Latino, or Spanish origin. For purposes of this report, "Youth of Color" is defined as any non-White youth who may or may not be of Hispanic, Latino, or Spanish origin.

Racial Distribution of Referred Youth

Over half the youth referred to the OCSOC were non-Hispanic, White (N=255, 56%) (Figure 1). About one-quarter were Hispanic youth of any race (N=109, 24%); 14% (N=63) were non-Hispanic, Black or African American; and 6% (N=29) were non-Hispanic, multi-racial youth. (Data were missing for 19 cases.)

Overall, more boys than girls were enrolled in the OCSOC (59% and 41%, respectively). This is consistent with national SOC data.[2] The racial composition of each gender was roughly equivalent and mirrored the overall racial distribution. For example, more than half of both boys and girls were non-Hispanic, White.

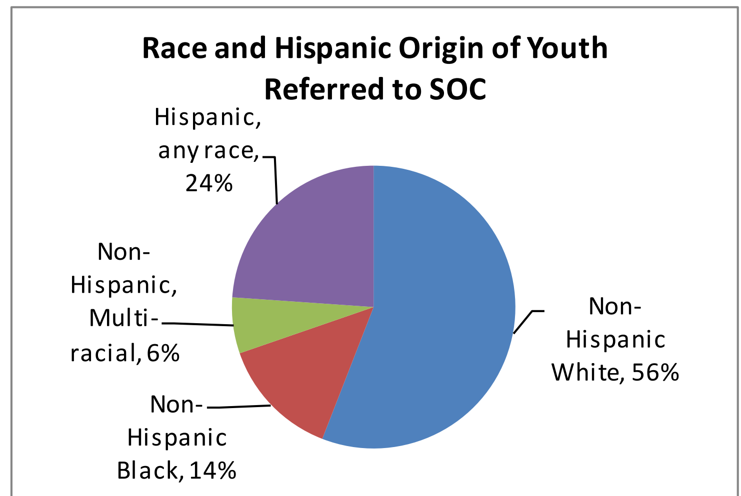


Figure 1

Racial Distribution by Referral Source

Compared to non-Hispanic, White youth, Youth of Color were significantly more likely to be referred from child welfare agencies (including Family Court) (28% and 72%, respectively) (Table 1). Schools also referred more Youth of Color than non-Hispanic, White youth (60% vs. 40%), but this difference was not significant.

Overall, mental health agencies continue to be the primary referral source of youth to OCSOC, accounting for more than half of all referrals (54%).

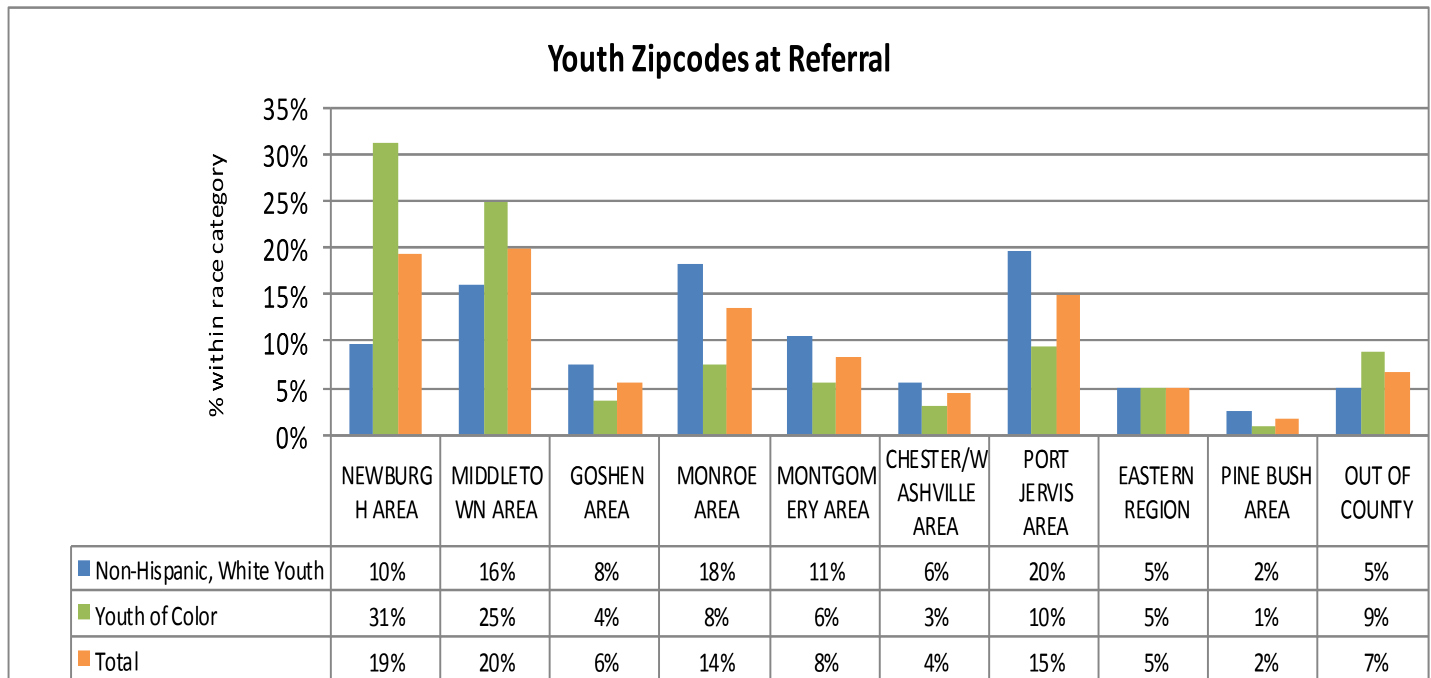
Table 1. Racial Distribution by Referral Source

Referral Source	Non-Hispanic, White Youth	Youth of Color	% of all referrals
Child Welfare	28%	**72%***	13%
Mental Health	60%	40%	**54%**
Juvenile Justice	55%	45%	9%
School/Education	40%	60%	17%
Caregiver/Self	66%	34%	8%

*Statistically significant (p=.05).

Residence at Time of Referral

Residence is strongly associated with race and ethnicity. More than half the Youth of Color lived in the Newburgh (31%) and Middletown (25%) areas at the time of referral to the OCSOC (Figure 2). Non-Hispanic White youth tended to come from the Port Jervis, Monroe, Middletown, and Montgomery areas. "Out of county" youth are typically in residential placement when referred to OCSOC and return to Orange County upon discharge.



	NEWBURGH AREA	MIDDLETOWN AREA	GOSHEN AREA	MONROE AREA	MONTGOMERY AREA	CHESTER/WASHVILLE AREA	PORT JERVIS AREA	EASTERN REGION	PINE BUSH AREA	OUT OF COUNTY
Non-Hispanic, White Youth	10%	16%	8%	18%	11%	6%	20%	5%	2%	5%
Youth of Color	31%	25%	4%	8%	6%	3%	10%	5%	1%	9%
Total	19%	20%	6%	14%	8%	4%	15%	5%	2%	7%

Figure 2

Outreach Efforts

In Year 3 of the initiative, OCSOC shifted its cultural equity and outreach efforts to attract a more diverse and culturally reflective population of youth into the system of care. Results of these efforts are reflected, in part, in the increase in enrollment of Black/African American youth in Years 3 and 4 compared with enrollment numbers prior to Year 3 (an increase from 9% to 20% of all enrolled youth) (Figure 3). The proportion of Hispanic, Latino, or Spanish youth has remained virtually unchanged at about 25%. Compared with the 2011 Orange County Patient Characteristics Survey,[3] Youth of Color are now slightly over-represented among youth enrolled in the OCSOC.

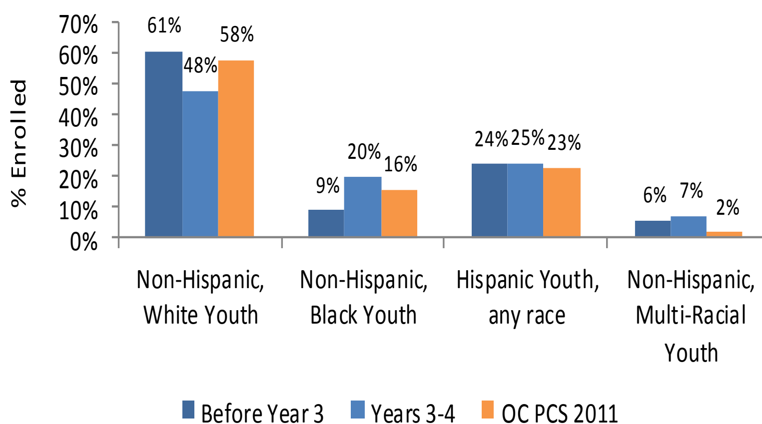


Figure 3

Racial and Ethnic Disparities in Children's Mental Health

Assessment and Diagnosis

Recent studies have found racial differences in diagnoses of youth. Youth of Color are more likely to be diagnosed with externalizing, behavioral disorders, while White youth are more frequently diagnosed with internalizing, mood/anxiety disorders.[4,5] Explanations for this include: ethnocentric clinician bias in the diagnostic assessment of youth from differing cultural/racial backgrounds;[4] differences in how groups seek care, with minority groups seeking care only after substantial decompensation;[5] and potential differences across cultures in how people express psychiatric symptoms or stress.[5]

The Orange County Experience

In contrast to the literature, there were no diagnostic discrepancies by race or ethnicity among youth in the OCSOC. While slightly more Youth of Color were diagnosed with externalizing, behavioral disorders as compared to non-Hispanic, White youth (53% vs. 49%), this small difference was not statistically significant.

In consideration of shifts in the racial composition of youth after the initiation of cultural equity and outreach efforts in Year 3, we analyzed whether there were accompanying shifts in diagnostic patterns. We found that prior to Year 3, Youth of Color were roughly 8 percent more likely to present with externalizing disorders relative to non-Hispanic, White youth. This difference is not statistically significant. There were no notable differences in diagnoses across racial/ethnic groups after Year 3.

These findings may reflect the ongoing cultural equity training and other efforts initiated in Year 3.

Effect of Culture on Service Access and Utilization

Only about 1 in 5 children with mental health issues receive the care they need.[6] Youth from minority racial/ethnic groups are even less likely to receive care.[6] Studies have found that Hispanic/Latino youth are least likely to receive treatment, with estimates that they are one-third as likely to receive mental health services compared to White children.[7,8,9,10]

Holm-Hansen[11] summarizes the literature on the reasons for these disparities, which include:

- The role of poverty
  - ⇒ Financial barriers, limited transportation, lack of insurance coverage
  - ⇒ Reduced accessibility to quality services in high-poverty areas
- The role of societal and institutional racism
  - ⇒ Mental health providers may interpret youth behaviors differently based on race/ethnicity
  - ⇒ Incongruent beliefs between providers and consumers about the causes and treatment of mental health problems can affect compliance as well as treatment outcomes
- Differences in referrals
  - ⇒ White individuals are more likely to self-refer for mental health services
  - ⇒ Youth of color, especially Black/African American youth, are more likely to be referred for restrictive placements than community-based services

(continued)

- Differences in belief systems
  - ⇒ Parents of minority cultures may under-identify behaviors or symptoms as a mental health concern
  - ⇒ Parents of minority cultures may be more likely to believe that mental health issues have a spiritual rather than biological basis
  - ⇒ Parents of minority cultures tend to believe that their child's mental health issues are due to their child rearing practices, thereby assuming blame and internalized stigma
- Stigma regarding mental health
  - ⇒ Differences in beliefs about mental health can result in varying levels of stigma experienced by individuals from different racial/ethnic groups
- Negative perceptions of treatment
  - ⇒ Parents of minority cultures generally have more negative perceptions of treatment compared to majority parents
- Lack of culturally appropriate services
  - ⇒ Shortage of trained mental health professionals representing diverse cultural communities
  - ⇒ Mental health services may not reflect a family's culture or values

Measuring Cultural Competence In Orange County

The cultural competence of service providers is captured through the Cultural Competence and Service Provision (CCSP) questionnaire. This survey was designed specifically for the SAMHSA system of care initiative and is part of the interview protocol for the national longitudinal evaluation.

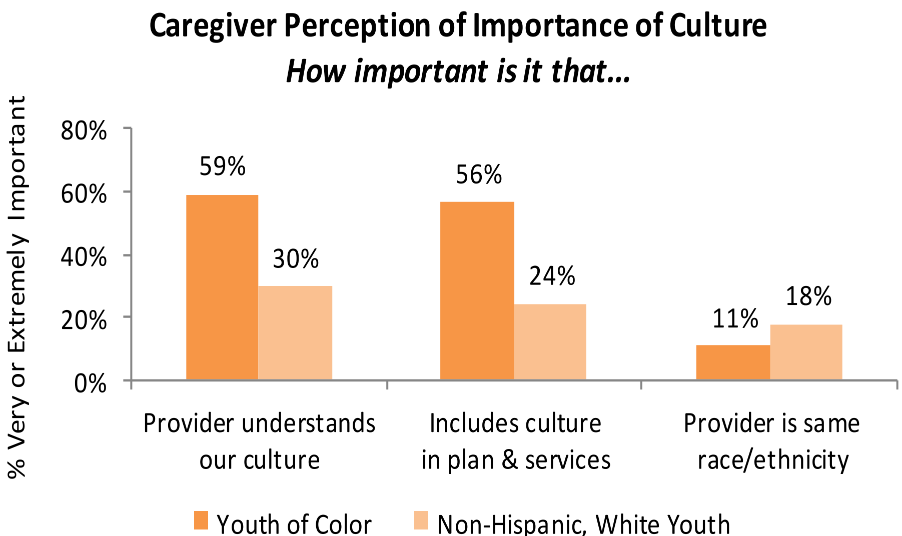
The CCSP asks caregivers about the importance of cultural heritage in their lives and services, and their perspectives on whether their child's primary provider considers their family's beliefs, traditions, and practices when providing services. Questions are asked of caregivers within the context of the child's experience with the service provider who works with them the most often.

The CCSP is administered starting at the first 6-month interview and at each follow-up interview. There were 76 respondents to this survey at the time of this report.

The Orange County Experience

Importance of Culture in Families' Lives

There were some differences in how caregivers felt about the importance of culture. Significantly more caregivers of Youth of Color than caregivers of non-Hispanic, White youth felt it is important for their service provider to understand their families' customs, practices, and traditions (59% and 30%, respectively) (Figure 4). Significantly more caregivers of Youth of Color than caregivers of non-Hispanic, White youth also felt it was important to include those beliefs in their child's service plans (56% and 24%, respectively). However, very few caregivers in either group felt is was "very" or "extremely" important to have their child's primary service provider be of the same race or ethnicity as their child (11% of caregivers of Youth of Color and 18% caregivers of non-Hispanic, White youth). Regardless of the perceived importance, 86% of non-Hispanic, White youth did have a provider of the same racial or ethnic group, while only 16% of Youth of Color had a provider of the same racial or ethnic group.



*Statistically significant (p=.05)

Figure 4

The Orange County Experience

How often do providers address families' cultural traditions, beliefs, and values?

High percentages of caregivers in the OCSOC reported that their service providers often understand their beliefs, discuss alternative therapies, and are comfortable interacting with their families (Figure 5). These perceptions were similar across racial/ethnic groups. On the other hand, less than half of the caregivers felt their service providers asked about the family's traditions (47% of caregivers of Youth of Color and 36% of caregivers of non-Hispanic, White youth reported that providers asked about traditions "Most of the time" or "Always"). Fewer caregivers of Youth of Color than caregivers of non-Hispanic, White youth felt their providers attended to their cultural needs (46% and 60%, respectively). These differences were not statistically significant.

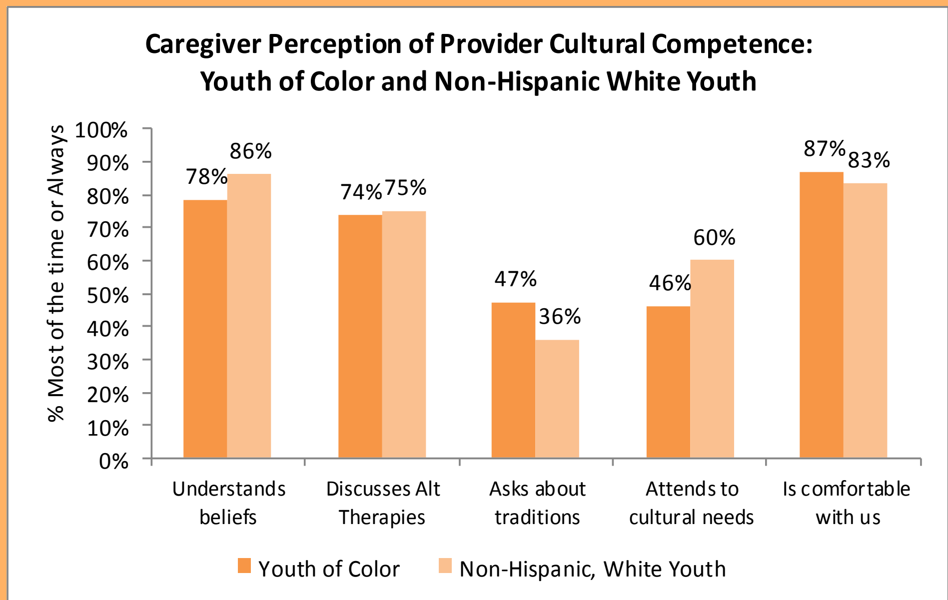


Figure 5

The Orange County Experience

Does having a provider of the same race/ethnicity make a difference in perceptions of care?

We might expect that having a provider who shares the same cultural heritage would positively influence caregivers' perceptions of the cultural competence of the services they receive. We did not find this effect. In fact, we found that high percentages of caregivers in both racial/ethnic groups felt their providers addressed their cultural needs *regardless* of whether the race or ethnicity of their provider was the same as their children's.

We also found no significant differences in perceptions of care between the two groups when the provider was the same race/ethnicity as the child. For example, when the provider's race/ethnicity matched the child's, 90% of caregivers of Youth of Color and 84% of caregivers of non-Hispanic, White youth felt their service provider understood their family's cultural beliefs (Figure 6).

This may indicate a growing base of cultural equity among providers in the OCSOC. In other words, high percentages of caregivers reporting a general sense of respect from their providers may reflect culturally equitable practice across providers regardless of the providers' race or ethnicity. Anecdotal data from respondents suggest that the bottom line for families is to be treated with respect and provided with appropriate services.

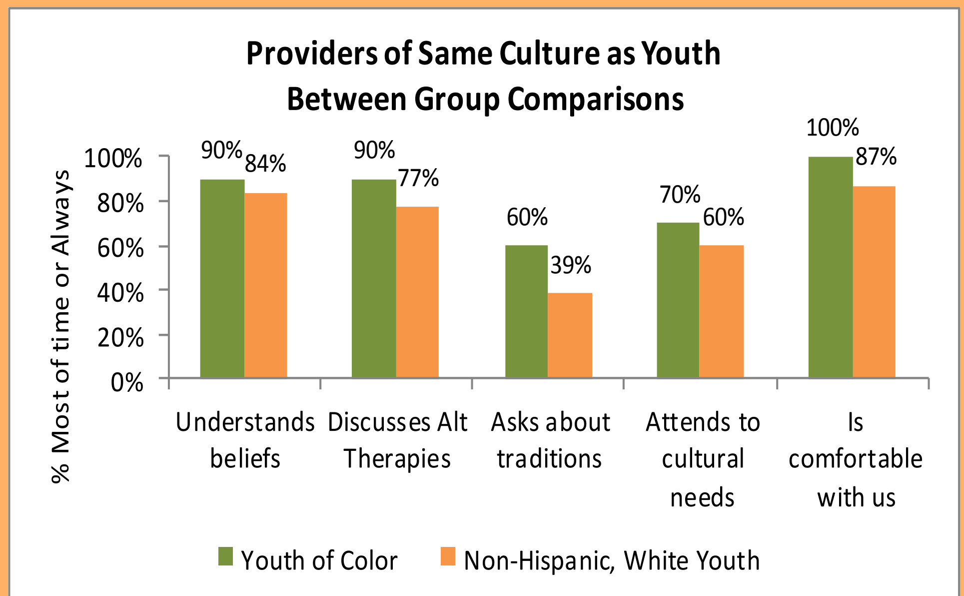


Figure 6

The Orange County Experience

When we look within cultural groups, having a provider of the same culture resulted in slightly more positive perceptions of cultural competence, but these differences were not statistically significant. For example, when the provider matched the culture of Youth of Color, 100% of caregivers reported their provider felt comfortable with them compared with 82% when the provider did not match (Figure 7).

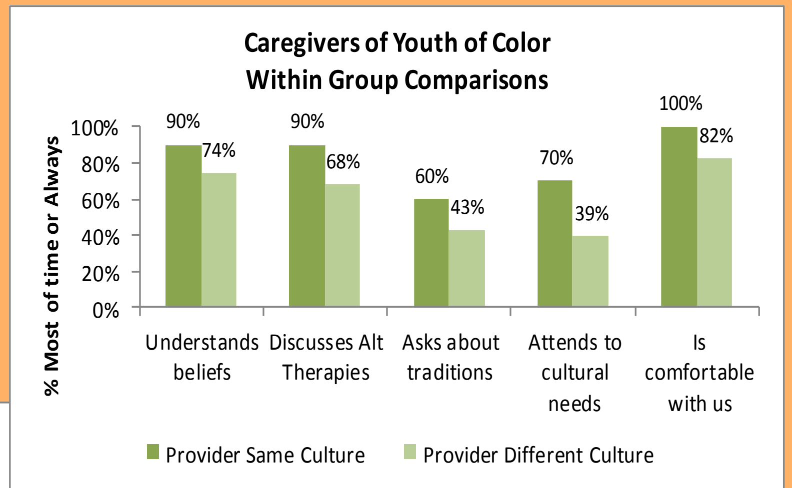


Figure 7

Similarly, when the provider of non-Hispanic, White youth was of the same culture, 87% of caregivers reported their provider felt comfortable with them compared with 60% when the provider did not match (Figure 8). Interestingly, fewer caregivers felt their child's provider understood their beliefs when the provider matched their child's culture (84%) than when they did not match (100%). None of the differences were statistically significant.

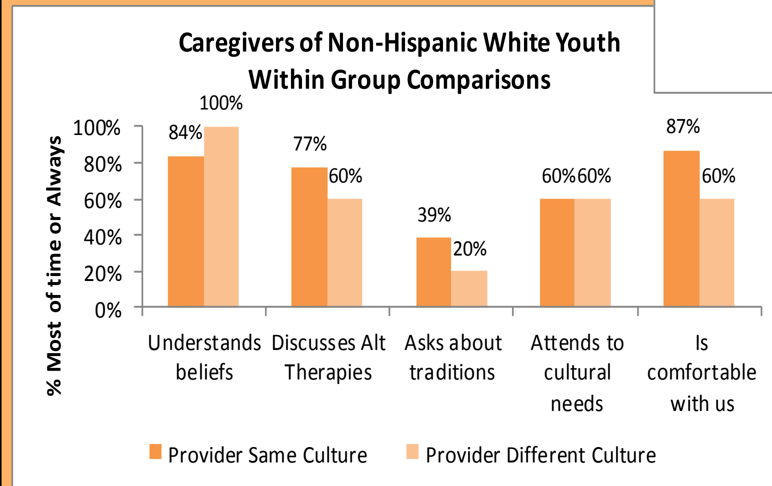


Figure 8

Summary and Conclusions

Positive Effects of Cultural Equity Efforts

The effect of targeted outreach and cultural equity efforts initiated throughout the Orange County System of Care in Year 3 are reflected in several findings presented in this report.

- Enrollment of Youth of Color, particularly Black/African American youth, increased over time such that Youth of Color are now slightly over-represented among youth enrolled in the OCSOC compared with youth served by mental health agencies in Orange County, or the U.S. Census.
- Enrollment of Hispanic/Latino youth has remained at about one-quarter of all enrollments over time, reflecting the population of Hispanic/Latino youth in the county.
- Slight differences in diagnoses of youth from different racial/ethnic groups prior to Year 3 were mitigated in Years 3 and 4.
- The fact that caregivers reported high levels of culturally competent care, and that there were no significant differences between or among racial groups, reflects positively on the cultural equity training, outreach, and other efforts throughout the Orange County System of Care.

Areas for Continuing Efforts

Having providers who understand and incorporate the family's culture into services and planning is important to caregivers. However, having a provider of the same race/ethnicity is neither important nor influential on caregivers' perception of the cultural equity of their service provider as long as there is a fundamental sense of respect for the family. Caregivers reported high levels of cultural equity on many items. Asking about traditions and attending to cultural needs received the lowest scores, indicating areas for further training and support.

Information about the Evaluation

As part of the Cooperative Agreement, SAMHSA requires each system of care to participate in a national evaluation coordinated by ICF Macro. There are multiple components of the national evaluation. The two components that are relevant to this *Research Brief* are described below. For more information about the evaluation activities, please visit www.mysystemofcare.org/howarewedoing.

Descriptive Study

- Descriptive data are required on all children/youth entering the system of care.
- Name of form: Enrollment and Demographic Information Form (EDIF). Completed by intake staff.
- Includes: Demographic characteristics (age, race, sex, etc.), social and functional characteristics, mental health diagnoses and presenting problems.
- Anonymous data are entered into a web-based application managed by ICF Macro.

Longitudinal Child and Family Outcome and Service Experience Study

- A sample of eligible families are interviewed at intake into the system of care and every 6 months for 24 months.
- In-person interviews are conducted by trained field interviewers from the Center for Human Services Research, University at Albany.
- Combination of questionnaires and standardized instruments regarding: Children's emotional and behavioral status, strengths, educational performance, criminal justice system involvement, living environments, caregiver stress and strain, family functioning, service utilization, and child and family satisfaction with services.
- Convenience sampling to reach enrollment target of 80 families per year, starting in Year 2.
- One parent/caregiver per family reports on one identified child/youth.
- Children/youth older than 10 years old can participate.
- Voluntary participation; monetary incentives.
- Computer-assisted personal interview (CAPI) software; confidential, de-identified data uploaded to web-based database managed by ICF Macro.

Data Sources for this Research Brief

- Descriptive Data: EDIF, data file downloaded April 15, 2012. N=475 youth records available for analysis.
- Perceptions of Cultural Competence: CCSP, data file downloaded April 15, 2012. N=76 respondents at 6-month interview available for analysis.

Statistical Note

- We used the Chi-square test of significance. It is sensitive to sample size. As the sample grows, these differences will likely lead to statistically significant differences. We will continue to monitor the data.

Resources

[1] U.S. Census Bureau. (2001). *U.S. Census 2000, Summary Files 1 and 2.* Retrieved October 15, 2011 from http://www.census.gov/main/www/cen2000.html.

[2] Substance Abuse and Mental Health Services Administration. (2012). *CMHS National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program*. ICF Macro, Atlanta, GA.

[3] The Patient Characteristics Survey (PCS) is a biennial, one-week survey of all persons served by the mental health system in New York State, reported by county. New York State Office of Mental Health. (2011). *2011 Patient Characteristics Survey: Orange County.* Retrieved June 13, 2012 from http://bi.omh.state.ny.us/pcs/Summary%20Reports.

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[11] Holm-Hansen, C. (2006). *Racial and ethnic disparities in children's mental health*. Wilder Research, St. Paul, MN.

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