Charlottesville/Albemarle Commission on Children and Families Task Force on Race Disparity and Disproportionality in Youth Services

Final Report
May, 2011

Presented on September 7, 2011

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Introduction

In July, 2009, the Charlottesville/Albemarle Commission on Children and Families convened a Task Force on Race Disparity and Disproportionality in Youth Services. National research shows that young children, children living in low-income households, and non-Caucasian children are at the highest risk for disparate outcomes; and, while poverty is a risk factor for all children, race and ethnicity *additionally* contribute to this risk. Therefore, addressing differences in access to, use of, and service delivery from these systems, while providing comprehensive services, especially in early childhood, can have long-range, positive impacts on a lifetime of physical, emotional, and intellectual development and health.

The Task Force's charge was:

1) Identify whether there are disparities affecting minority children of Charlottesville and Albemarle in the areas of mental health, physical health, child welfare, and juvenile justice, and if so, to determine the level and scope of disparities.
2) Determine the consequences or results of any identified disparities.
3) Determine the causes of any identified disparities
4) Elicit community input, reaction, and recommendations related to identified disparities
5) Identify strategies to address identified minority disparities, and
6) Make action recommendations to CCF.

Task Force members included:

- Rudy Beverly, University of Virginia
- Sgt. Philip Brown, Charlottesville Police Department
- Jacki Bryant, Children, Youth & Family Services, CCF
- Martha Carroll, 16th District Court Services Unit, CCF
- Millar Hunter, St. Paul's, Ivy
- Robert Johnson, Region Ten Community Services Board
- Winx Lawrence, University of Virginia, CCF
- Sarah McConnell, Virginia Foundation for the Humanities
- Barbara Oudekerk, University of Virginia
- Lilian Peake, Charlottesville/Albemarle Health Department
- Ronnie Price, Albemarle School Board, CCF
- Jessie Ray, Partnership for Children
- Dick Reppucci, University of Virginia
- Maurice Walker, CCF
- Melvin Wilson, University of Virginia

The Task Force developed a work plan that detailed activities and methodology to:

1) Gather available local data about disparity
2) Conduct research on best practices and current local practices
3) Identify key stakeholders to interview about causes and implications of disparity. Conduct interviews and focus groups.

4) Formulate preliminary recommendations.

The Task Force was extremely fortunate to have the assistance of Professor Dick Reppucci's Community Psychology and Prevention Science (PSYC7480) seminar. The students, their community laboratory instructor Barbara Oudekerk, and Maryfrances Porter, formerly CCF Intervention Team Leader conducted research, analyzed data, and completed reports. The research findings are synopsized in this report. Full reports are included in the appendices to this document.

The research team included.

- Lindsay Doswell
  University of Virginia, Educational Psychology: Applied Developmental Sciences
- Myles Durkee
  University of Virginia, Educational Psychology: Applied Developmental Sciences
- Elizabeth Gale-Bentz
  University of Virginia, Department of Psychology
- Faiza Jamil
  University of Virginia, Educational Psychology: Applied Developmental Sciences
- Joshua Richards
  University of Virginia, Department of Environmental Sciences
- Todd Warner
  University of Virginia, Department of Psychology

Further research on best practices in the juvenile justice was completed by Erin Garrett, CCF intern.

This report contains an Executive Summary of findings and recommendations, followed by lengthier synopses of research findings, descriptions of best practices, and recommendations with strategies. The Appendices include specific research findings including statistical analysis.

Executive Summary of Findings and Recommendations

I. Juvenile Justice

Findings:

- African American youth are disproportionately represented in the juvenile justice system. In Charlottesville, they are 1½ times more likely to be placed on probation compared to Caucasian youth.
- African American and Caucasian youth do not differ significantly on family, school, or individual risk factors in either locality.
- African American and Caucasian youth do not differ significantly in Department of Juvenile Justice Risk Assessment Tool scores in either locality.
- Data showed no difference between African-American and Caucasian offenders classified as having high overall risk, high school risk, high individual risk or low overall risk.
- Data showed no differences between African American and Caucasian youth with regard to number of prior offending behaviors and interactions with juvenile justice.
- African American youth were overrepresented in arrest rates, referral to intake, petitioned, diverted (Albemarle County only), probation, detention, and confinement. African American youth were between 4 and 7 times more likely to receive these consequences in Albemarle County and between 2 and 3 times more likely to receive these consequences in Charlottesville compared to Caucasian youth.
- African American youth are more than 1½ times more likely that Caucasian youth to go to detention in Albemarle County,
- In Charlottesville, Caucasian youth are more than 4 times more likely to be diverted from the juvenile justice system.
- In Charlottesville, African American youth are about 1½ times more likely to be put on probation or sent to detention.

Recommendations:

- Expand mentoring opportunities for African American youth, particularly young men.
- Develop model sets of policy and procedure at every step in the juvenile justice process: street, arrest, intake, adjudication, sentencing, incarceration.
- Develop a “shepherding” program for youth entering the juvenile justice system to provide guidance and advocacy.
- Provide effective engaging training in cultural proficiency to juvenile justice staff (police, probation officers, etc.)
- Further examine the intersection of school and juvenile justice
- Expand job training and employment opportunities for youth as a means of preventing involvement in the Juvenile Justice system

II. Child Welfare

Findings:

- African American youth are disproportionately represented in CSA services. In Charlottesville, the probability of being referred to CSA services was about 4 times greater for African American youth versus Caucasian youth. In Albemarle, the likelihood of receiving CSA services was about 3 times higher for African American youth.
- In Albemarle, African Americans are more likely to receive services for delinquency and victimization and Caucasians are more likely to receive services for internalizing problems.
- African American and Caucasian youths' cases did not vary significantly in length in Albemarle County. In Charlottesville, Caucasian youth stayed, on average, 13 months longer than African American youth.
- There were no differences in the types of services African American and Caucasian youth received.

Recommendations:

- Promote culturally competent early identification and interventions services.
- Provide culturally competent foster care.
- Promote culturally competent permanency and reunification services
- Provide effective engaging training in cultural proficiency to child welfare staff.

III. Physical Health

Findings:

- Childhood obesity is higher for African American children than for Caucasian children.
- Infant mortality is higher for African Americans than for Caucasians.
- Low birth weight is more prevalent for African American babies than for Caucasian babies.

Recommendations:

- Implement the strategies developed by the Community Obesity Task Force to address childhood obesity.
- Implement the strategies developed by the Improving Pregnancy Outcomes Work Group to address infant mortality and low birth weight.
- Provide effective engaging training in cultural proficiency to health care providers.

IV. Mental Health (Research focused on clients of Region Ten Community Services Board)

Findings:

- African American youth are over-represented in RTCSB service use, whereas Caucasian youth are underrepresented, proportional to the population at large. The likelihood of

receiving RTCSB services is 3 times higher for African American youth than for Caucasian youth in both Albemarle and Charlottesville.
- Behavioral disorder diagnoses did not significantly differ across race in either Albemarle County or City of Charlottesville.
- Mood/anxiety/adjustment disorder diagnoses did not significantly differ across race
- Average scores on the Global Assessment Functioning did not vary significantly across race for youth living in Albemarle County or City of Charlottesville.

Recommendations:

- Continue to promote the Systems of Care Practice Model
- Promote development of best practices approaches to mental health treatment.
- Provide effective and engaging training in cultural proficiency to mental health providers.

Section I
Juvenile Justice

Analysis of Local Data

In 2007, graduate students from the University of Virginia conducted file reviews to gather data on 298 juvenile offenders who were on probation for at least 2 months in 2004, 2005, and/or 2006. Youth ranged in age from 12 – 19, and the majority of whom were boys (77%). Most youth identified as African American (54%) or Caucasian (38%). Only 3% identified as Latino/Latina and 3% as bi-racial; because these percentages were so small, these youth were not included in the current analyses. All analyses were conducted using this data unless otherwise stated.

The results strongly suggested that African American and Caucasian youth in the juvenile justice system show similar risk patterns across family, school, individual and juvenile justice variables. Therefore, any disparities with regard to race appear to be the result of patterns of arrest and subsequent decision making regarding consequences.

As shown in Figure 1-1, African American youth are disproportionately represented in the juvenile justice system. The disparity is particularly profound in Charlottesville where African American youth were 1½ times more likely to be placed onto probation compared to Caucasian youth.

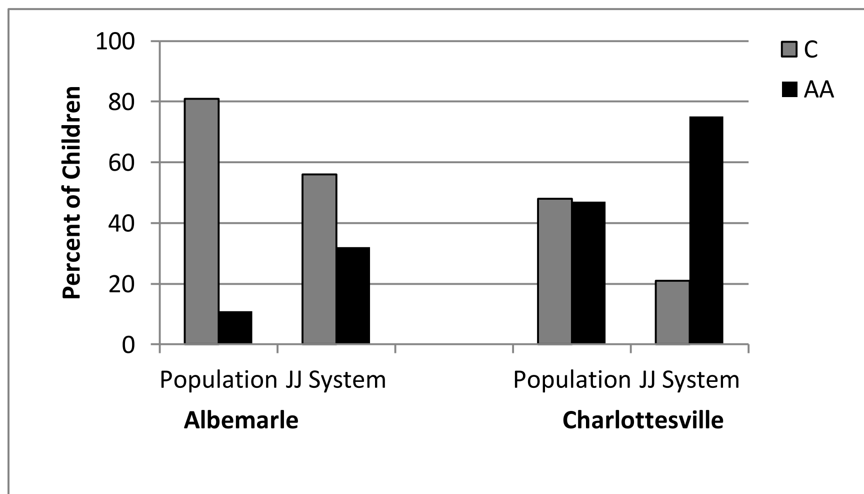


Figure 1-1. The percent of African American and Caucasian youth aged 10-17 in the Juvenile Justice System compared to the percent in the population in Albemarle County and City of Charlottesville. **Data obtained from Virginia Department of Criminal Justice Services Research Unit.**

As shown in Figure 1-2, African American and Caucasian youth do not differ significantly on family, school, or individual risk factors in either locality.

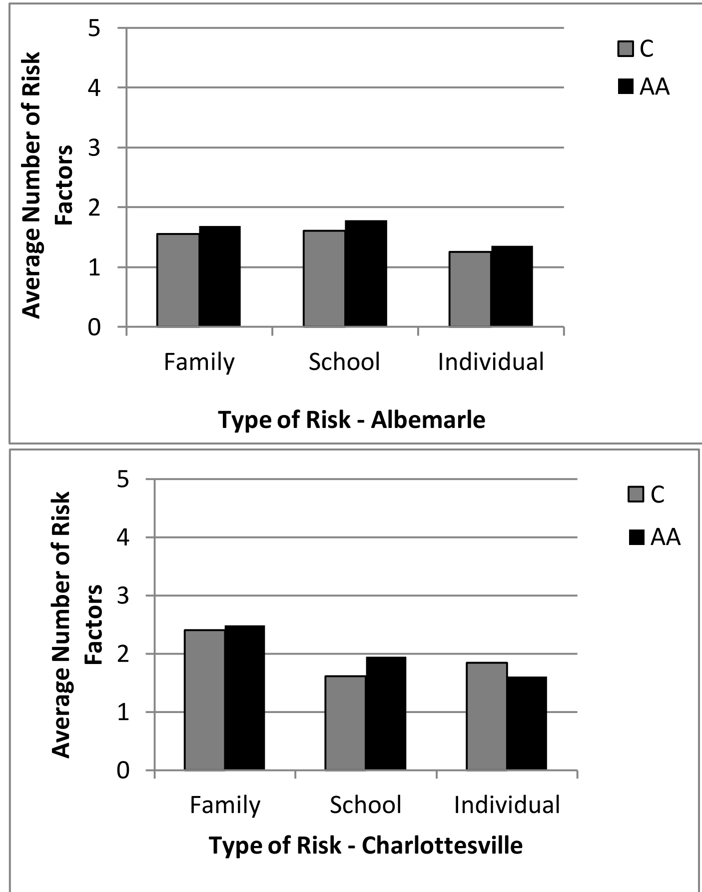


Figure 1-2: Average number of family, school, and individual risk factors for African American and Caucasian youth in the Juvenile Justice system in Albemarle County and City of Charlottesville.

Figure 1-3 shows that African American and Caucasian youth do not differ significantly in Department of Juvenile Justice Risk Assessment Tool scores in either locality.

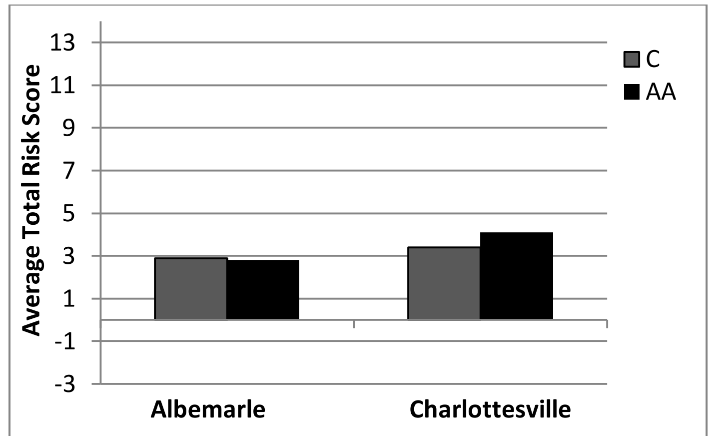
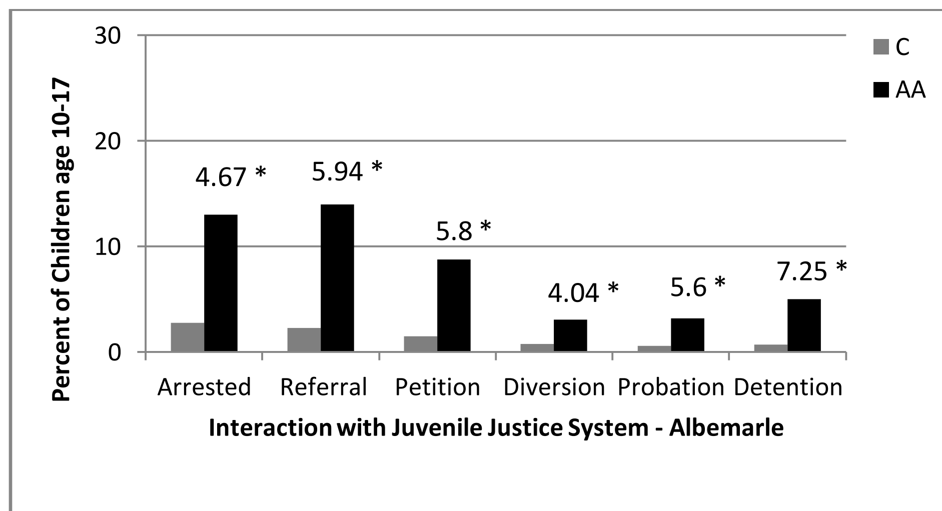
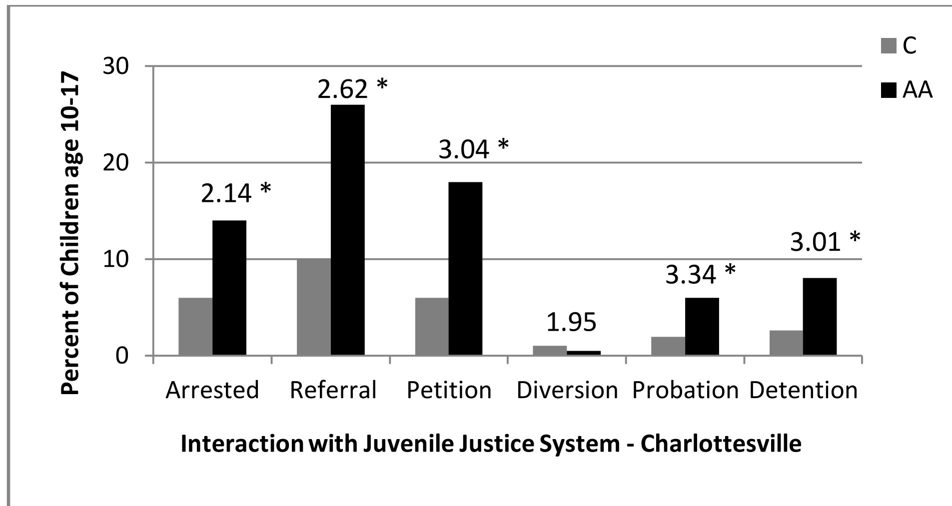


Figure 1-3: Average scores for African American and Caucasian youth in the Juvenile Justice System on the Risk Assessment Tool in Albemarle County and City of Charlottesville.

Additional analyses of juvenile justice data showed no difference between African-American and Caucasian offenders classified as having high overall risk, high school risk, high individual risk or low overall risk. Further analyses were conducted to understand variables associated with offending behavior (i.e., age at first referral; prior offenses; prior probation; prior detention admissions; prior sentenced admissions; and curfew violations) Results of these analyses revealed 2 groups: high and low interactions. After the analysis was complete, a breakdown of race for each group was examined. Results revealed no differences between African American and Caucasian youth with regard to number of prior offending behaviors and interactions with juvenile justice

Analyses were conducted to understand the consequences received by youth following an alleged offense. As shown in Figures 1-4, results indicated African American youth were overrepresented in arrest rates, referral to intake, petitioned, diverted (Albemarle County only), probation, and detention. Because so few youth were placed in confinement, subsequent analyses could not be interpreted for this group (Albemarle: 5 AA, 4 Cau, 1 Other; and Charlottesville: 12 AA, 2 Cau, 3 Other). African American youth were between about 4 and 7 times more likely to receive these consequences in Albemarle County and between 2 and 3 times more likely to receive these consequences in Charlottesville compared to Caucasian youth.





Figures 1-4: Juvenile Justice consequences for African American and Caucasian youth in Albemarle County and the City of Charlottesville. **Data obtained from Virginia Department of Criminal Justice Services Research Unit.**

Finally, follow-up analyses explored youths risk for subsequent juvenile justice consequences after accounting for disparity in arrests. Figures 1-5 show that subsequent disparities do exist: African American youth are more than 1½ times more likely that Caucasian youth to go to detention in Albemarle County; in Charlottesville, Caucasian youth are more than 4 times more likely to be diverted, and African American youth are about 1½ times more likely to be put on probation or sent to detention.

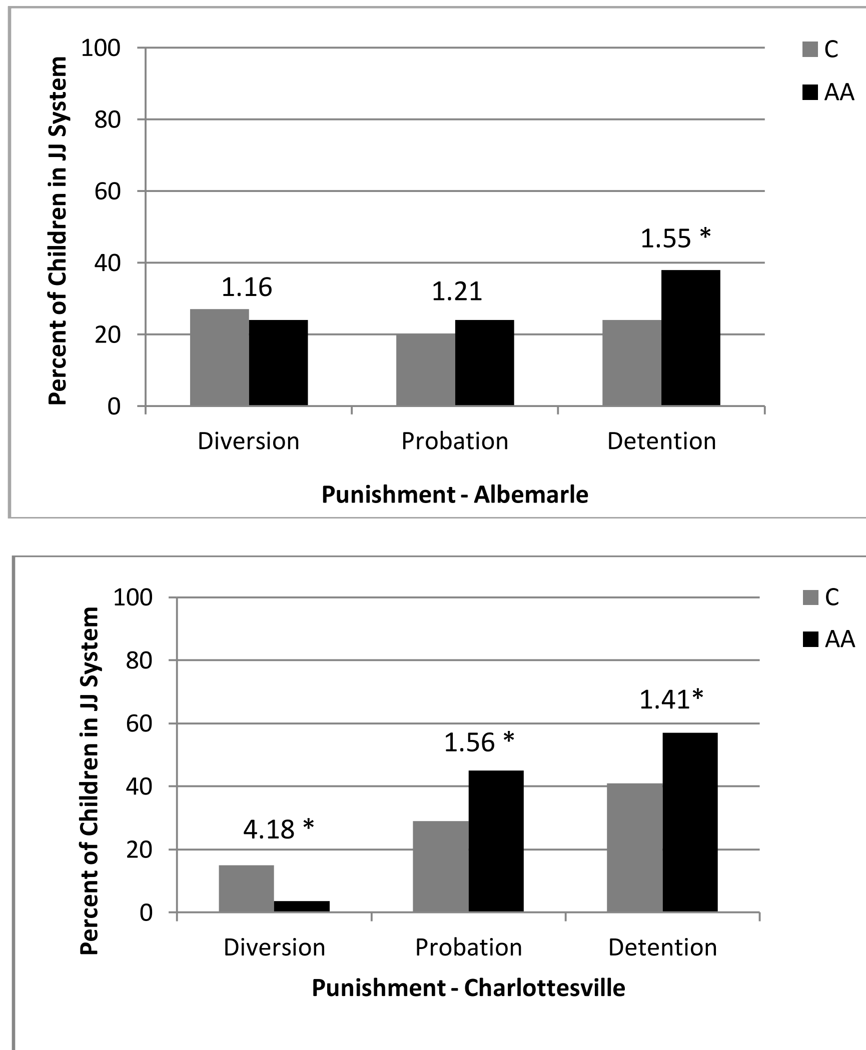


Figure 1-5: Subsequent juvenile justice consequences (after accounting for disparities in referral for intake) for African-American and Caucasian youth in Albemarle County and the City of Charlottesville. **Data obtained from Virginia Department of Criminal Justice Services Research Unit.**

Critical Components of Best Practices for Reducing Disproportionate Minority Contact (DMC) in the Juvenile Justice System

1. ***Design a comprehensive, multimodal approach:*** Develop multiple strategies and implement them concurrently at several decision points in the juvenile justice process. Design strategies aimed at attacking multiple DMC factors simultaneously.
2. ***Foster collaboration among stakeholders:*** Set a formal structure in place for collaboration across agencies and key stakeholders in the community and delegate clear, well-defined roles, responsibilities, and steps to ensure accountability.
3. ***Choose interventions that the community is ready to implement:*** Assess community readiness and identify strategies that have the greatest likelihood of succeeding.
4. ***Use evidence-based strategies and draw on successful experiences of current DMC initiatives:*** Select programs or interventions that have program elements that have been researched and are associated with positive outcomes.
5. ***Provide cultural competency training:*** Provide training on cultural awareness and diversity to *all* key decision makers in the juvenile justice process, including police officers, probation officers, judges, district attorneys, public defenders, corrections officers, intake officials, and case managers.
6. ***Gather reliable data at key decision points in the juvenile justice process:*** Use of reliable data is crucial not only for diagnosing any current potential problems in the juvenile justice process, but also to evaluate the impact of prior intervention strategies set forth.
7. ***Use objective criteria:*** Employ objective, empirically-validated assessment tools to determine key decisions in juvenile's cases, especially with regard to placement of youth into secure facilities. However, recognize that even the best assessment tools do not predict risk with the same level of accuracy across gender and race/ethnicity. Provide opportunities for key decision-makers to learn about these limitations.
8. ***Implement alternatives to detention to keep youth connected to their communities:*** To keep youth better connected with their families and communities, alternatives to detention must be set in place with a focus on community-based interventions, monitoring, reporting and services provided to youth/families.
9. ***Case processing reforms:*** Focusing on expediting case processing can greatly reduce the length of stay for juveniles. Additionally, it helps ensure that interventions for youth rehabilitation are timely and appropriate.
10. ***Careful management of "special" detention cases:*** Reexamine cases in which youth are detained for probation violations, writs, warrants, and awaiting trial. A reexamination may produce more appropriate placements for youth in secure custody.

Recommendations for
Reducing Disproportionate Minority Contact (DMC) in the Juvenile Justice System

Recommendation 1: Expand mentoring opportunities for African American youth, particularly young men.

Strategies:

- Seek funding for an evidence-based mentoring program
- Implement and evaluate mentoring program using timeline and strategies developed in grant application.

Recommendation 2: Develop models sets of policy and procedure at every step in the juvenile justice process: street, arrest, intake, adjudication, sentencing, incarceration.

Strategies:

- Gather examples from other localities and clearinghouses such as OJJDP
- Draft model policies and procedures for each level.
- Present models to key stakeholders for feedback.
- Refine models.
- Stakeholders adopt and implement models

Recommendation 3: Develop a "shepherding" program for youth entering the juvenile justice system to provide guidance and advocacy.

Strategies:

- Continue discussion with Legal Aid/UVA Law School and identify other potential partners.
- With partner organization(s), design pilot project
- Conduct and evaluate pilot.

Recommendation 4: Provide effective engaging training in cultural proficiency to juvenile justice staff (police, probation officers, etc.)

Strategies:

- Develop local champions
- Identify high quality training opportunities
- Find resources to support training
- Train local champions to provide training
- Provide and evaluate training

Recommendation 5: Further examine the intersection of school and juvenile justice.

Strategies:

- Obtain additional data about how and what kind of referrals are made and results of referrals.
- Map the rate and racial make-up of school behavior entry into juvenile justice system
- Interview principals about school practices
- Determine the role of School Resource Officers in juvenile justice referrals and/or prevention

- Identify tools for SROs to use to interrupt the cycle of juvenile justice involvement

Recommendation 6: Expand job training and employment opportunities for youth as a means of preventing involvement in the Juvenile Justice system

Strategies:

- Inventory existing programs, including criteria for participation, number served, race breakdowns
- Research effectiveness and efficiency of these programs
- Build capacity to expand effective programs

Section II
Child Welfare

Analysis of Local Data

Analysis focused specifically on children within the Comprehensive Services Act (CSA) system, because of the availability of adequate information. Specifically, youth served under this system are in foster care or receiving services to prevent foster care. Data were analyzed from 571 youth receiving services under the Comprehensive Services Act (CSA) in the 2008 fiscal year. There were 265 youth from Albemarle County and 306 youth from the City of Charlottesville.

Overall, results demonstrated that African American youth are disproportionately represented in CSA services, especially in Charlottesville. While all youth enter CSA services with the same amount of need or risk, there are racial differences in the reasons why youth need services and the type of services they receive.

Figures 2-1 and 2-2 illustrate that African American youth are disproportionately represented in CSA services in Charlottesville and Albemarle County, more so in Charlottesville. In Charlottesville, the probability of being referred to CSA services was about 4 times greater for African American youth versus Caucasian youth. In Albemarle, the likelihood of receiving CSA services was about 3 times higher for African American youth.

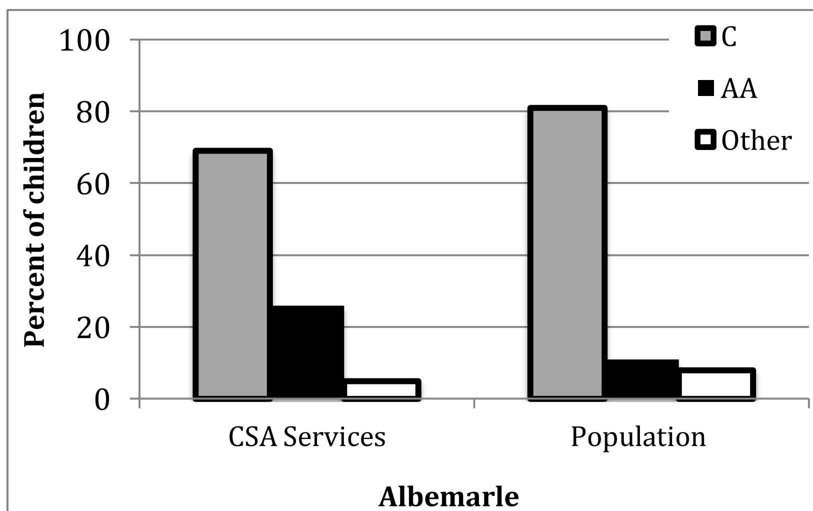


Figure 2-1. Percent of youth receiving CSA services in Albemarle County (2008) and percent of youth living in Albemarle County (2007)

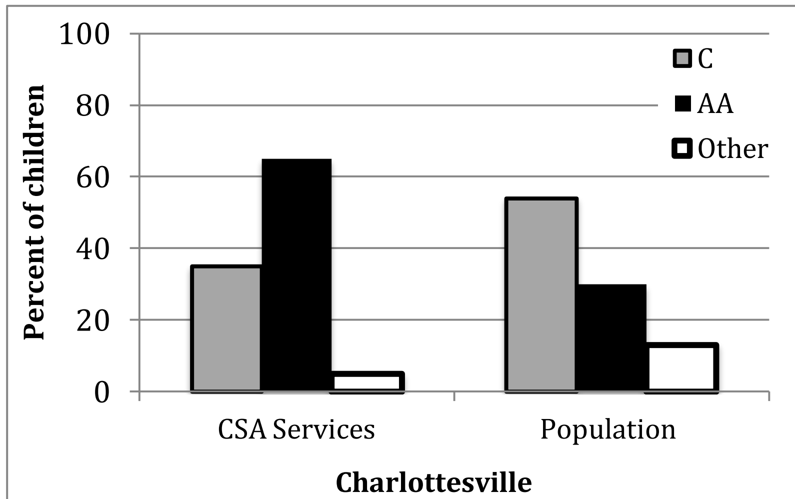


Figure 2-2. Percent of youth receiving CSA services in Charlottesville (2008) and percent of youth living in Charlottesville (2007) who are African American versus Caucasian. *Denotes a statistical difference at $p < .05$.

All youth who received CSA services in 2008 were administered a mandatory uniform assessment instrument (MUAI) to assess their needs. Youth's MUAI scores ranged from 0 – 200 in Albemarle and 0 – 230 in Charlottesville; higher scores represent greater need. As shown in Figure 2-3, Caucasian youth in Albemarle scored, on average, about 15 points higher than African American youth (this difference just misses being statistically significant). However, there were no differences in MUAI scores for Caucasian and African American youth living in Charlottesville.

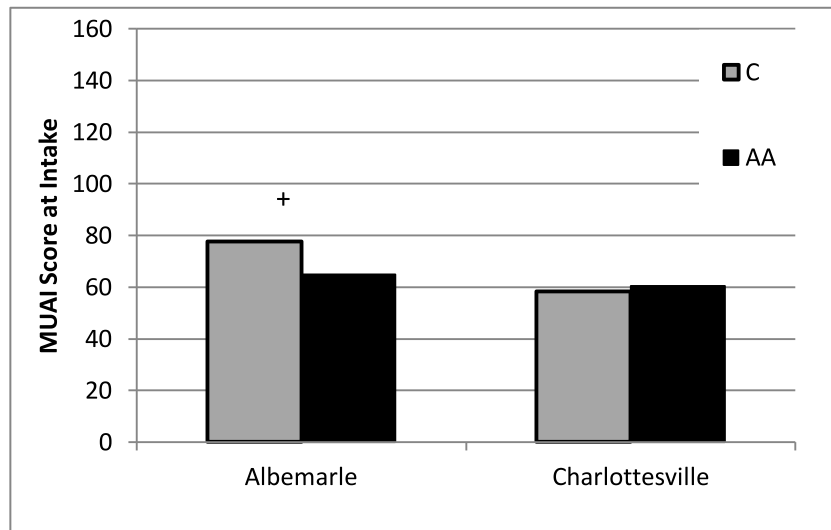


Figure 2-3. Youth's MUAI Intake Score for Albemarle County and City of Charlottesville. + Denotes a statistical difference at p=.07

Figures 2-4 and 2-5 illustrate the reasons for entering the CSA service system. For these analyses, the service reasons were combined into three variables: delinquency (e.g., illegal activity, truancy), victimization (e.g., abuse, neglect) and internalizing problem (e.g., emotional problem, mental disorder). Figure 2-4 shows that, in Albemarle, African Americans are more likely to receive services for delinquency and victimization and Caucasians are more likely to receive services for internalizing problems. In Charlottesville (Figure 2-5) African American and Caucasian youth enter the CSA service system for the same reasons. There were no significant differences in age of referral by race or locality. The majority of youth are referred for services in early to mid adolescence. In Charlottesville, on average African American and Caucasian youth were referred to CSA services at 11 years old. Similarly, in Albemarle County the average age at referral was 10 years old. African American and Caucasian youth's cases did not vary significantly in length in Albemarle County. In Charlottesville, Caucasian youth stayed, on average, 13 months longer than African American youth (Mean = 20 months and Mean =33 months respectively).[i]

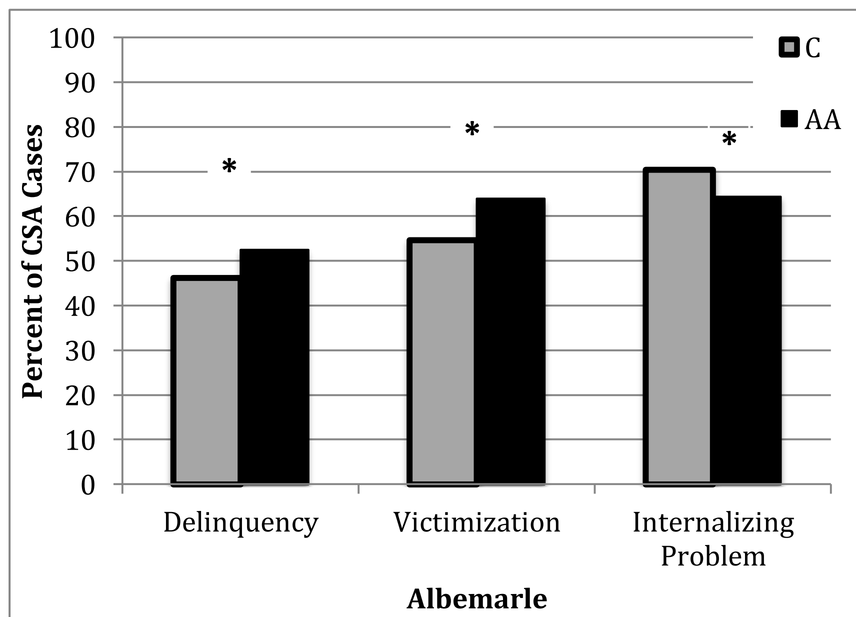


Figure 2-4. Percent of African American and Caucasian youth living in Albemarle County who received CSA services for delinquency, victimization, and internalizing problems, 2008.
***Denotes a statistically significant difference at $p < .05$**

[i] A t-test analysis suggest this is not a statistically significant difference at the cut off score of $p < .05$; $t\,(1, 66) = 1.67$, $p = .10$.

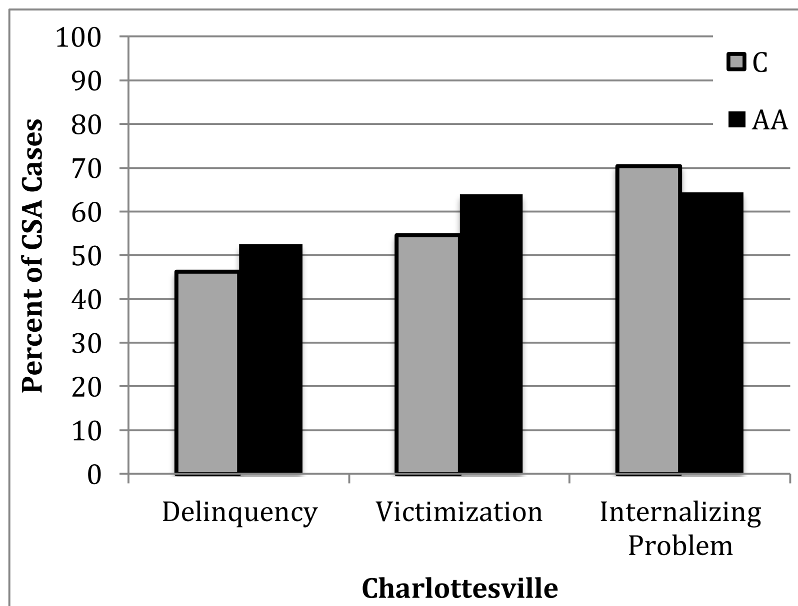


Figure 2-5. Percent of African American and Caucasian youth living in the City of Charlottesville who received CSA services for delinquency, victimization, and internalizing problems, 2008.

Figure 2-7. Percent of youth mandated to Foster Care Prevention or Foster Care, Albemarle County and City of Charlottesville, 2008. + Denotes a statistical difference at $p < .08$

Further analysis was made of youth in foster care *prevention* services (FCP) versus foster care services (which includes family foster care, residential foster care, and treatment foster care) in Albemarle and Charlottesville. In Albemarle, Caucasian youth were slightly more likely to be placed into foster care prevention (FCP) services than African American youth (Relative Risk =1.17), but were no more or less likely to be placed into any type of foster care. In contrast, Caucasian youth were slightly more likely than African American youth to be placed into any type of foster care in Charlottesville (Relative Risk=1.17), but were not more or less likely to receive FCP services.

Lastly, analyses were conducted to determine whether African American and Caucasian youth were equally likely to be served in the community versus placed into residential congregate care (i.e., a group home or residential treatment facility). There were no differences in the types of services African American and Caucasian youth received in Albemarle County or the City of Charlottesville.

Critical Components of Best Practices for Addressing Disproportionality and Disparity in Child Welfare

1. ***Identify at-risk families and provide foster care prevention services***: conduct full-family assessments and use strengths-based interventions to help empower and inform at-risk parents.
2. ***Promote permanency***: reduce the time to permanency for youth in the foster care system by promoting family-centered practices, initiatives to recruit minority adoptive or foster parents.
3. ***Aim for Reunification***: strive to preserve family connections while the youth is away from home, reunify youth with their families in as short amount of time as possible, and provide services that assist families during transitions.
4. ***Improve in-home services***: providing consistent, in-home services to families; make services accessible to all types of families and work with families on an individual-level.
5. ***Acknowledge cultural values when deciding where to place youth***: place youth in an environment that reflects his/her cultural values; support kinship care services so that the youth can stay in his or her community.
6. ***Provide support services for foster families***: create community support groups for foster and adoptive parents; incorporate team decision-making strategies; provide parenting support.
7. ***Provide equal services to youth in kinship and nonkinship care***: provide financial, legal and emotional support to kinship parents. Assist kinship parents in navigating the social service system and help them access support services and benefits.
8. ***Increase support services for youth***: recruit family, friends and other professionals who have a vested interest in the youth's long-term safety and well-being; create a stable support group that is involved in decisions regarding the youth's welfare.
9. ***Promote cultural competence:*** increase supervisors' and caseworkers' sensitivity to prejudice and discrimination by training them to be better prepared to work with culturally and racially diverse populations.
10. ***Combat institutional racism***: increase awareness about the implicit or explicit biases that affect decision making within the child welfare system and recognize the ability for some policies disproportionately to affect certain populations (e.g., non-Caucasian and low socioeconomic youth).

Recommendations for
Reducing Disproportionate Minority Contact in the Child Welfare System

Recommendation 1: Promote culturally competent early identification and interventions services

Strategies:

- Identify at-risk families and provide foster care prevention services: conduct full-family assessments and use strengths-based interventions to help empower and inform at-risk parents. Be more specific about recommendations.
- Create parent mentor advocacy programs improving school welcoming policies. Need to engage schools more. Survey parents. Get input. Use Safe Schools to help with this,
- Refer infants and family to home visiting services as early as possible, including mutual peer support.
- Improve in-home services: providing consistent, in-home services to families; make services accessible to all types of families and work with families on an individual-level.

Recommendation 2: Provide culturally competent foster care.

Strategies:

- Acknowledge cultural values when deciding where to place youth: place youth in an environment that reflects his/her cultural values; support kinship care services so that the youth can stay in his or her community.
- Provide support services for foster families: create community support groups for foster and adoptive parents; incorporate team decision-making strategies; provide parenting support.
- Increase support services for youth: recruit family, friends and other professionals who have a vested interest in the youth's long-term safety and well-being; create a stable support group that is involved in decisions regarding the youth's welfare.
- Provide equal services to youth in kinship and nonkinship care: provide financial, legal and emotional support to kinship parents. Assist kinship parents in navigating the social service system and help them access support services and benefits.
- Provide specific training to foster parents in working with different races.

Recommendation 3: Promote culturally competent permanency and reunification services

Strategies:

- Promote permanency: reduce the time to permanency for youth in the foster care system by promoting family-centered practices, initiatives to recruit minority adoptive or foster parents.

- Aim for Reunification: strive to preserve family connections while the youth is away from home, reunify youth with their families in as short amount of time as possible, and provide services that assist families during transitions.

Recommendation 4: Provide effective engaging training in cultural proficiency to child welfare staff.

Strategies:

- Develop local champions
- Identify high quality training opportunities
- Find resources to support training
- Train local champions to provide training
- Provide and evaluate training

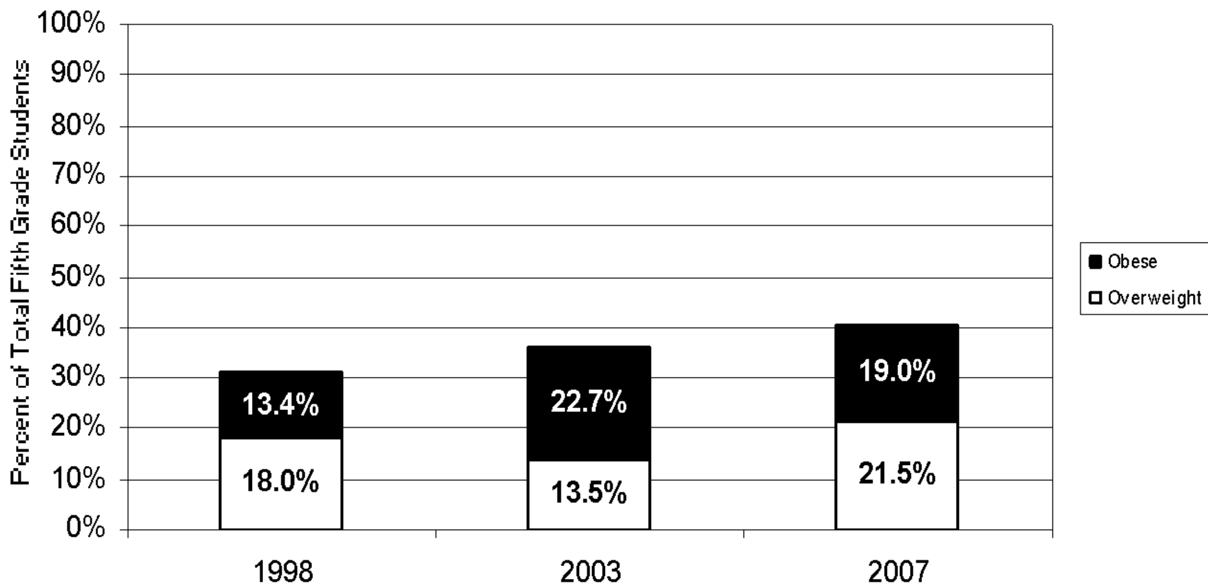
Section III
Physical Health

Analysis of Local Data

Data on youth's physical health was collected from the Centers for Disease Control and Prevention, Virginia Department of Health, Thomas Jefferson Health Department, and the Community Obesity Task Force in Charlottesville, Virginia, between 1997 and 2008.

Overall, the analyses revealed that there are racial disparities in the rates of childhood obesity, infant mortality, and low weight births. African American youth generally experience higher rates of negative health outcomes than Caucasian youth in the City of Charlottesville and Albemarle County.

Figure 4-1 illustrates that the rate of overweight and obese 5th graders in Albemarle and Charlottesville has generally increased overtime from 1998 to 2007.



*Overweight: BMI >85th to <95th percentile for age and sex
**Obese: BMI >95th percentile for age and sex
Source: Thomas Jefferson Health Department; Community Obesity Task Force

Figure 4-1. Prevalence of overweight and obese fifth graders in Charlottesville and Albemarle County during 1998, 2003, & 2007.

Figure 4-2 illustrates that the rate of obese youth is higher in Charlottesville for both males and females than the national average. Additionally, the difference between obesity rates for African American and Caucasian youth in Charlottesville is also present in the national prevalence of childhood obesity.

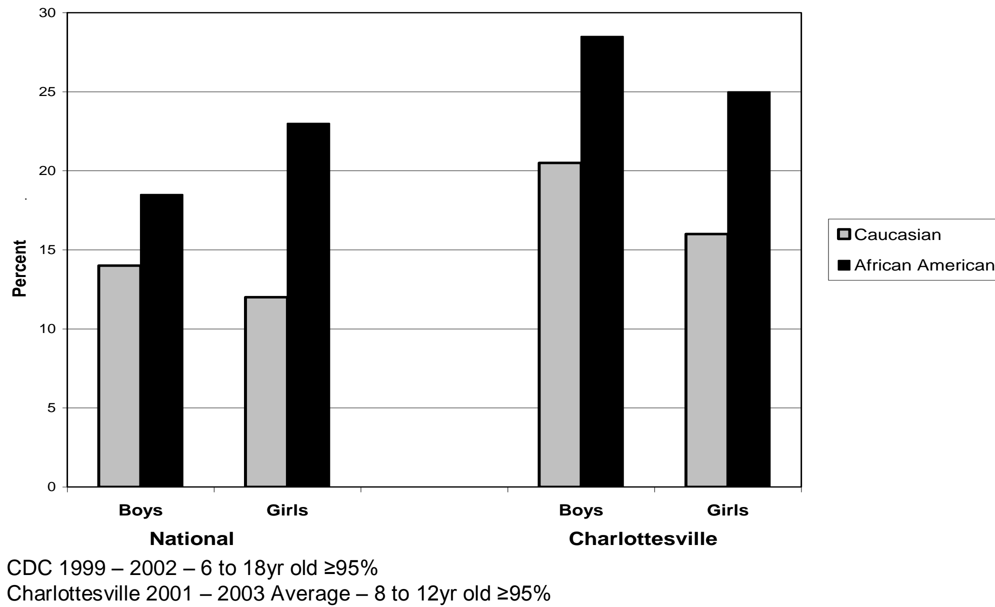


Figure 4-2. Prevalence of the Charlottesville and national rates of childhood obesity by race and gender.

As shown in Figure 4-3 the infant mortality rate is much higher for African American youth than for Caucasian youth in both Charlottesville and Albemarle County. In general, the infant mortality rate is higher in Charlottesville than Albemarle County.

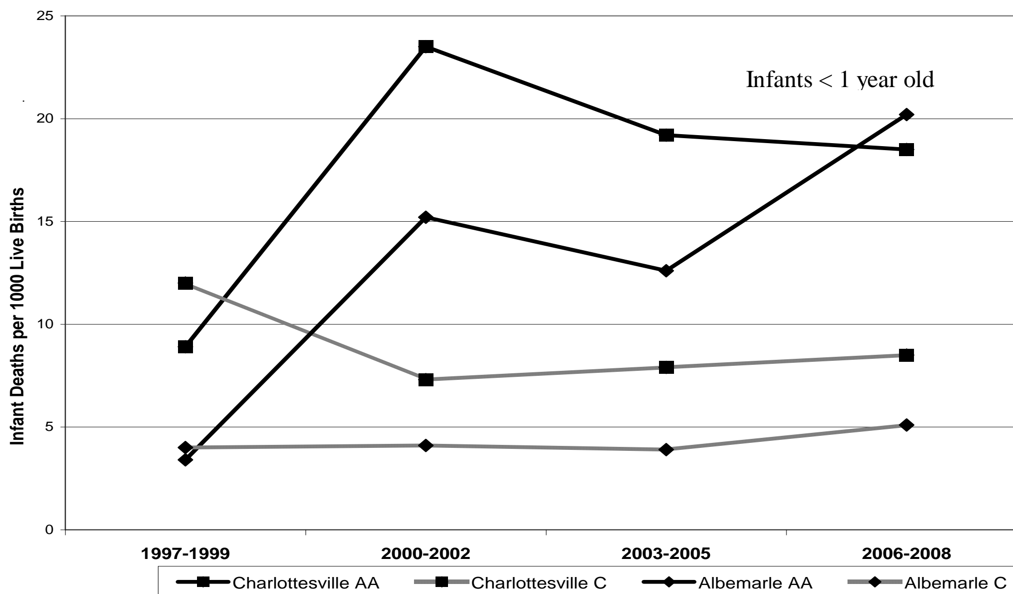


Figure 4-3. Infant mortality rate (per 1,000 live births) by race in Charlottesville and Albemarle County over three year averages from 1997 to 2008. Source: Virginia Department of Health- Center for Health Statistics

As shown in Figure 4-4 the percent of low weight births is much higher for African American youth than for Caucasian youth in both Charlottesville and Albemarle County. Additionally, the percent of low birth weight infants is generally higher in Charlottesville than Albemarle County.

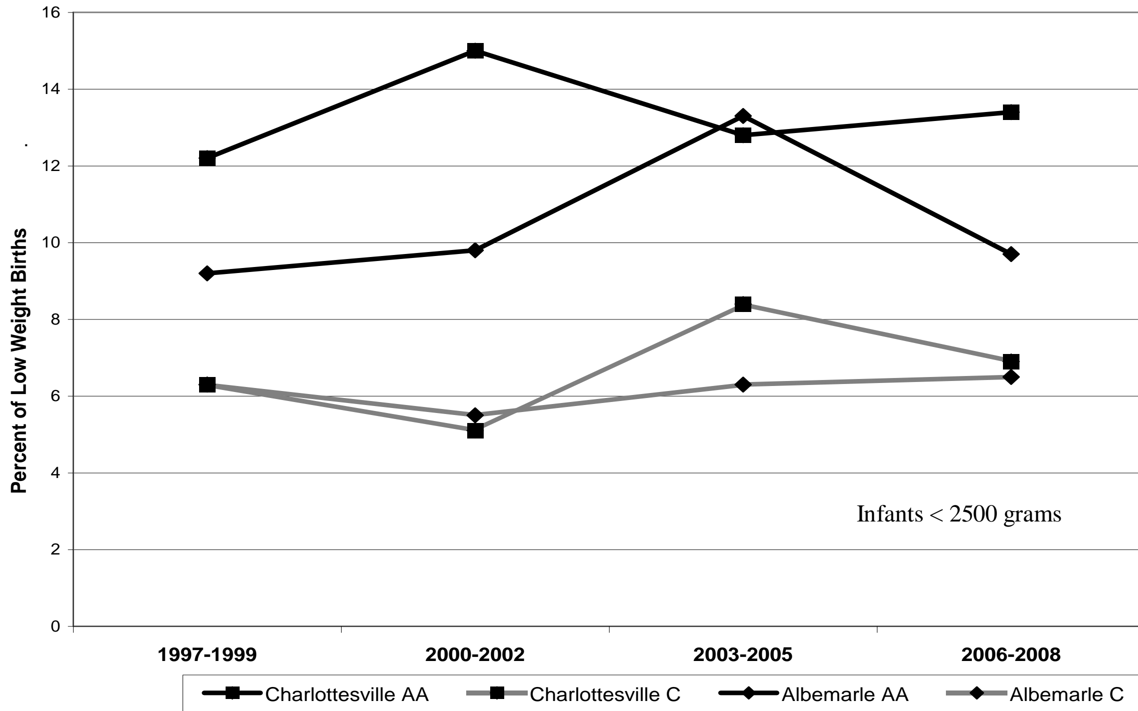


Figure 4-4. Percent of low weight births (< 2500g) by race within Charlottesville and Albemarle County over three year averages from 1997 to 2008. Source: Virginia Department of Health-Center for Health Statistics.

Critical Components of Best Practices for Addressing Disproportionality and Disparity in Physical Health

Childhood Obesity Prevention: Nutrition

1. ***Promote the availability of affordable healthy food/beverages:*** Improve the geographic availability of supermarkets in underserved areas and offer incentives for food providers to relocate and/or offer healthier choices.
2. ***Encourage healthy food/beverage choices:*** Restrict the availability of less healthy options in public service venues (i.e. public schools) and institute smaller portions of food. Also, limit advertisements for less healthy options and promote the consumption of healthy beverages (i.e. water, milk) over sugar-sweetened beverages.
3. ***Promote healthy nutrition as a lifestyle:*** Encourage residents to maintain a well-balanced diet and emphasize the importance of nutrition for well-being. Distribute nutritional information through communitywide campaigns and interventions to increase awareness.

Childhood Obesity Prevention: Physical Activity

1. ***Encourage physical activity or limit the amount of non-active behavior:*** Increase the amount of physical activity in school PE programs and increase opportunities for extracurricular physical activity. Reduce the amount of computer or television time in public service venues (i.e. YMCA, Boys and Girls Clubs).
2. ***Create safe communities that support physical activity:*** Improve access to outdoor recreational facilities and enhance the community infrastructure to support bicycling and walking. Locate schools within easy walking distance of residential areas and enhance traffic safety in areas where individuals may be physically active.
3. ***Promote fitness as a lifestyle:*** Implement communitywide campaigns and outreach programs to encourage residents to engage in routine physical activity and emphasize the importance of exercise as a component of good health.

Infant Mortality Prevention

1. ***Take a preventative approach to maternal and infant health:*** Promote good health and effective monitoring before conception and provide easily accessible health education and preconception counseling.
2. ***Ensure timely prenatal care for all women:*** Address the barriers to prenatal care regarding accessibility and awareness of Medicaid policies. Emphasize the timing and content of prenatal care.
3. ***Promote cultural competency among service providers:*** Emphasize cultural diversity among staff in order to foster trust and communication between staff and patients.
4. ***Improve the quality of care for low-income patients:*** Expand access to high-quality neonatal intensive care for preterm infants from low-income families.
5. ***Sustain efforts to prevent infant mortality after the first month of life:*** Increase public education campaigns that promote healthy practices (i.e. breastfeeding, infants sleeping on their backs). Ensure that all youth (even uninsured) receive regular medical check-ups.

Recommendations for
Reducing Disproportionate Minority Outcomes in the Physical Health System

Recommendation 1: Implement the strategies developed by the Community Obesity Task Force to address childhood obesity.

Recommendation 2: Implement the strategies developed by the Improving Pregnancy Outcomes Work Group to address infant mortality and low birth weight.

Recommendation 3: Provide effective engaging training in cultural proficiency to mental health providers.

Strategies:

- Develop local champions
- In collaboration with UCARES and others develop educational community specific training modules.
- Identify high quality training opportunities
- Find resources to support training
- Train local champions to provide training
- Provide and evaluate training

Section IV
Mental Health

Analysis of Local Data

Data were obtained on 557 youth with open cases at Region Ten Community Services Board (RTCSB) between 2001 and 2009. Of these, 250 youth (66% male) lived in Charlottesville and 307 (70% male) in Albemarle County. Youth ranged in age from 0 to 18, and the average age was 10 years old.

As shown in Figure 5-1, African American youth are over-represented in RTCSB service use, whereas Caucasian youth are underrepresented, proportional to the population at large. The likelihood of receiving RTCSB services is 3 times higher for African American youth than for Caucasian youth in both Albemarle and Charlottesville. Compared to Caucasian youth, youth from "other" racial backgrounds were 3 times more likely to receive mental health services in Albemarle and over 1.5 times more likely in Charlottesville.

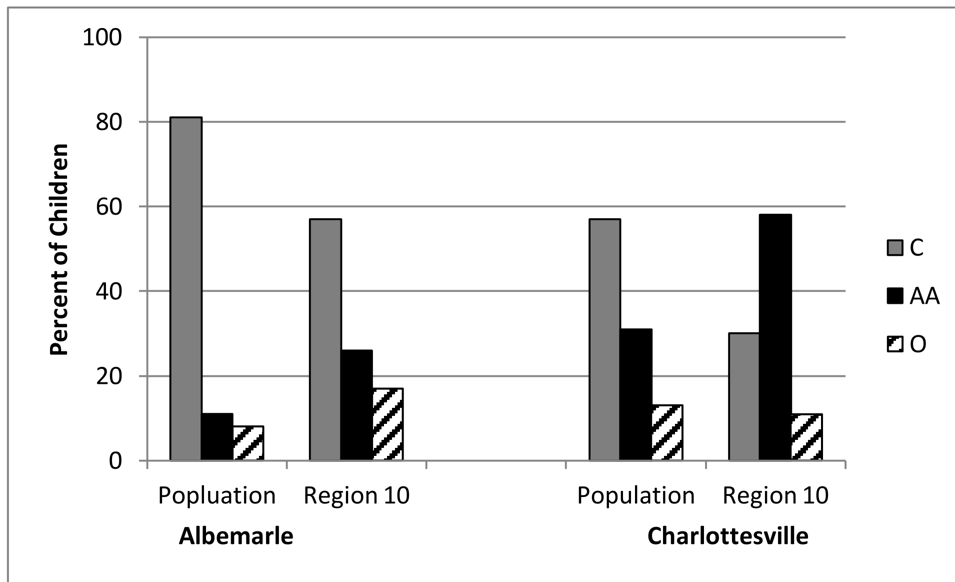


Figure 5-1. Percent of youth serviced by RTCSB compared to percent of youth in Albemarle County and the City of Charlottesville.

Figure 5-2 illustrates that the large majority of youth receiving RTCSB services were diagnosed with behavioral disorders or mood/anxiety/ adjustment disorders. Very few youth were diagnosed with developmental disorders, substance abuse, posttraumatic stress disorder, attachment disorders, or other disorders. Diagnosis deferred means that a primary diagnosis was not given.

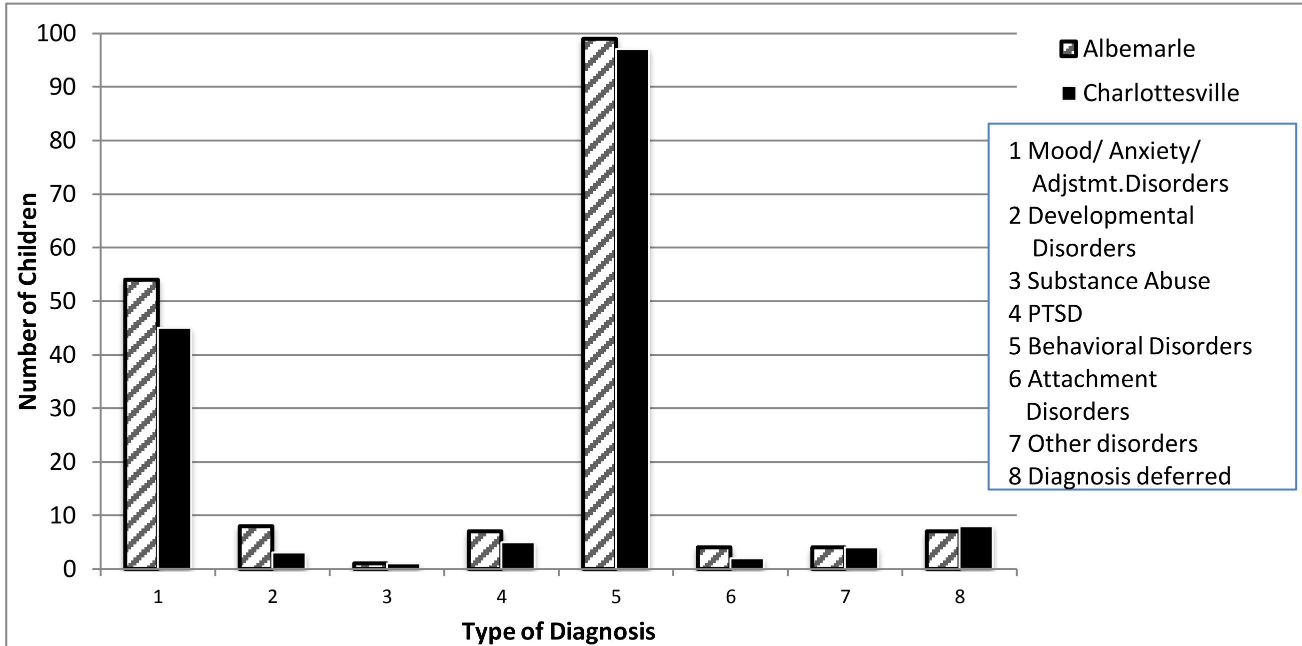
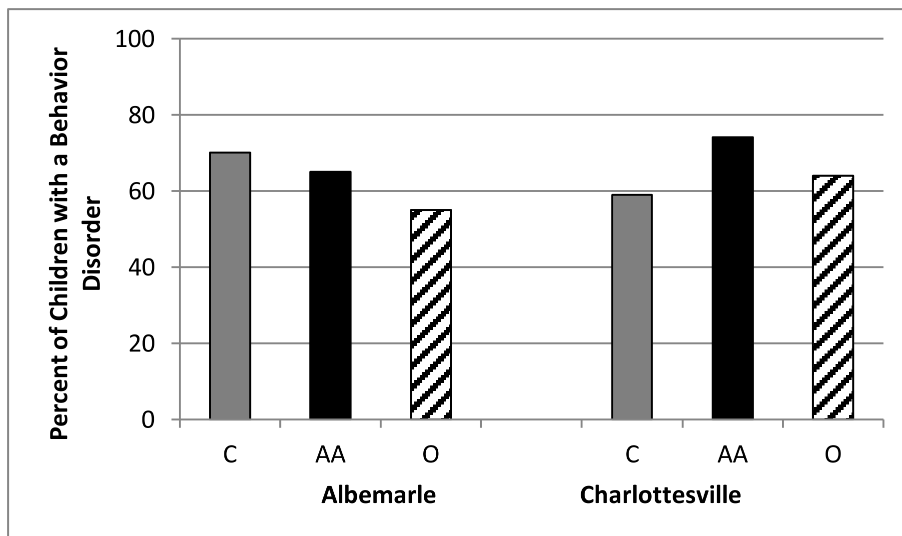


Figure 5-2. Primary diagnoses for youth living in Charlottesville and Albemarle County.

The research examined whether youth of different racial backgrounds are more or less likely to be diagnosed with behavioral disorders or mood, anxiety, or adjustment disorders. As shown in Figure 5-3, behavioral disorder diagnoses did not significantly differ across race in either Albemarle County or City of Charlottesville.



As shown in Figure 5-4, mood/anxiety/adjustment disorder diagnoses did not significantly differ across race in either Albemarle County or the City of Charlottesville, with the exception of youth in Charlottesville who were neither Caucasian nor African American- they were about 2 times less likely to be diagnosed with a mood/anxiety/ adjustment disorder (Relative Risk = 2.22).

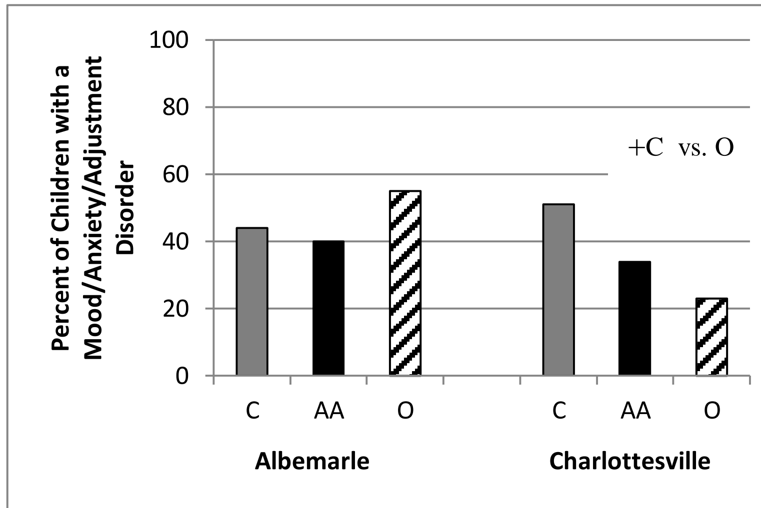


Figure 5-4. Percent of youth with a mood, anxiety, or adjustment disorder diagnosis by race in Albemarle County and the City of Charlottesville.
+ Denotes a statistical difference at $p < .08$.

As shown in Figure 5-5, average scores on the Global Assessment Functioning did not vary significantly across race for youth living in Albemarle County or City of Charlottesville.

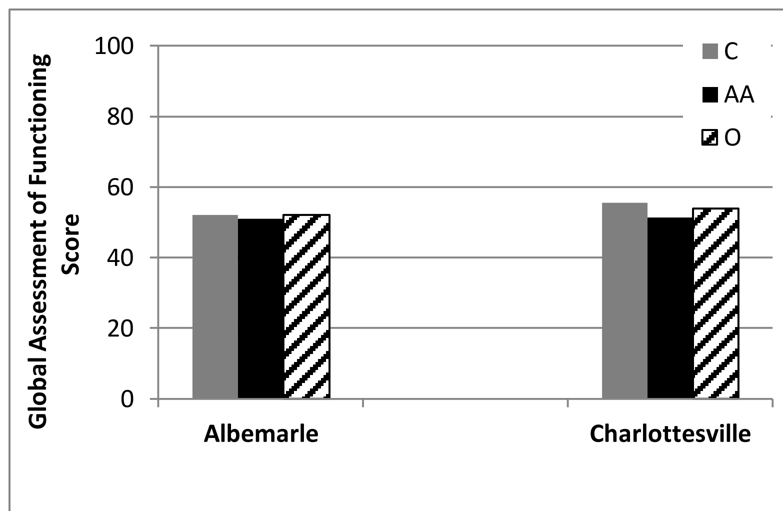


Figure 5-5. Average score of youth on the Global Functioning Assessment Scale by race in Albemarle County and the City of Charlottesville.

Critical Components of Best Practices for Addressing Disproportionality and Disparity in Mental Health

1. ***Emphasizes family-driven care:*** families are highly valued and sought out in decision-making processes regarding their child's mental health care needs.
2. ***Promotes a community-based care philosophy:*** services are provided to youth in the community in which they live.
3. ***Employs a strengths-based approach:*** youth and family strengths, take a prominent place in the assessment and service delivery process and are built upon and supported as part of the service plan; challenges and problems are viewed in the context of the child and family strengths.
4. ***Individualized approach:*** service plans are individually tailored to meet each youth's and family's unique needs; individuality is seen as an asset that can be utilized throughout the treatment process.
5. ***Services draw on families' support systems:*** service providers encourage extended family, friends, and mentors from important community networks (e.g., churches, schools) to be actively involved in the treatment process, and service plans are built to use and increase the natural supports available to the child and family.
6. ***Services reflect cultural sensitivity:*** service providers receive training in cultural diversity and learn how to tailor services to be culturally appropriate.
7. ***Services are culturally and linguistically accessible:*** service providers reflect racial/ethnic background of families being served, and bilingual providers work with non-English speaking families.
8. ***Service providers are aware of potential cultural biases in referrals and diagnoses:*** providers develop culturally and linguistically appropriate assessment, treatment, and referral procedures.
9. ***Service providers are cognizant of transportation needs:*** providers facilitate transportation to the agency, bring the service provider to the family's home or neighborhood, and/or let families choose service delivery locations.
10. ***Flexibility:*** services allow for flexible scheduling and billing options.
11. ***Interagency communication:*** all service providers foster interagency communication, cooperation, and partnerships within the community in order to provide youth with the most comprehensive service plan possible.

Recommendations for
Reducing Disproportionate Minority Contact in the Mental Health System

Recommendation 1: Continue to promote the Systems of Care Practice Model

Strategies:

- Use a community-based approach of mental health service delivery for youth and their families
- Create family-driven, strengths-focused treatment plans
- Promote the partnering of multiple organizations within a community in order to provide youth and their families with the most comprehensive, culturally competent services available.

Recommendation 2: Promote development of best practices approaches to mental health treatment.

Strategies:

- Identify best practices such as Multisystemic Therapy, Brief Strategic Family Therapy, Multidimensional Family Therapy.
- Build capacity by seeking funding to implement these programs.

Recommendation 3: Provide effective engaging training in cultural proficiency to mental health providers.

Strategies:

- Develop local champions
- In collaboration with UCARES and others develop educational community specific training modules.
- Identify high quality training opportunities
- Find resources to support training
- Train local champions to provide training
- Provide and evaluate training