

The Referral of Minority Adolescents to Community Mental Health Centers*

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Few investigations have examined the referral of minority adolescents to community mental health clinics. This issue is especially critical in light of the increased attention given to mental health services for children and adolescents in recent years. The present study uses mental health clinic data from a large metropolitan area to explore whether African Americans and Mexican Americans entering mental health care do so through referrals that are more coercive than those made for Whites. The total sample consists of 2,460 adolescents aged 13-17; the results indicate that African-American adolescents are more likely than Whites to be referred by an external agency. When types of external agencies are considered, African Americans enter community mental health care more often than Whites through referrals from social agencies; Mexican Americans enter more often than Whites through school referrals. This paper suggests that African-American adolescents' overrepresentation in community mental health clinics may in part be due to their disproportionate contact with social and legal agencies and the propensity of these agencies to rely more often on the mental health system than on families or schools. Among all variables considered in the analyses for this paper, poverty status demonstrated the most consistent and powerful association with coercive referrals.

INTRODUCTION

Two seemingly contradictory patterns are evident in the empirical literature on the use of public mental health services among African

Americans. The first is that African-American adolescents and adults are overrepresented in community mental health treatment facilities (Cheung and Snowden 1990; Fried 1975; Milazzo-Sayre et al. 1986; Rosenstein and Milazzo-Sayre 1981; Snowden and Cheung 1990; Sue et al. 1991). The findings from these investigations are contrasted with a second pattern that shows African Americans to be reluctant to seek help from mental health service providers (Broman 1987; Neighbors 1985; Neighbors and Jackson 1984). This reluctance is witnessed not only in the initial contact with a mental health professional but also is reflected in clinical studies in which African Americans are more likely to terminate prematurely from treatment, stay for a shorter period of time in outpatient clinics, and have

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poorer treatment outcomes than other minority groups and Whites (Hu et al. 1991; Sue et al. 1991). African Americans may resist the use of mental health services because they have a different conception of mental health problems than do Whites: they attach a stigma to mental health services; they have little faith in the benefit of psychotherapy; they fear institutionalization; and/or they have limited awareness of or access to existing services (Snowden and Cheung 1990; Sussman, Robins, and Earls 1987).

Less is known about the helpseeking behavior and the use of mental health services among other ethnic minority groups. What is known about these minority groups makes the patterns for African Americans even more intriguing. Unlike African Americans, for example, Mexican Americans tend to be underrepresented in mental hospitals and community mental health clinics (Cheung and Snowden 1990; Snowden and Cheung 1990). Barriers that constrain African Americans from seeking mental health care also are evident for Mexican Americans (Rogler, Malgady, and Rodriguez 1989). Some barriers are specific to Mexican Americans, as well. For example, many Mexican Americans are recent immigrants who may be more comfortable speaking a language other than English. These immigrants may resist using mental health programs that do not include a bilingual professional staff. Thus, for Mexican Americans, underrepresentation in mental health treatment facilities appears to be consonant with reluctance to seek professional care for problems. Given that a similar reluctance to seek help from mental health professionals appears to occur among different minority groups, why do the utilization patterns for African Americans and Mexican Americans differ?

Analyses reported in this paper examine one aspect of this question by focusing on the referral of adolescents to public mental health clinics. One possible reason for the discrepancy in findings between treatment and community studies is that African Americans may enter the mental health system under more coercive conditions than other minorities and Whites. The major purpose of the analysis is to determine whether African-American and Mexican-American adolescents are more likely to enter the mental health system through a different referral source than Whites. In this paper, a distinction is made

between an informal source as measured by a family referral, and a formal source such as a school counselor or probation officer. While some studies have examined the pathways to mental health treatment facilities for adults (Horwitz 1982; Rosenfield 1984), few investigations have concentrated on the referral of minority adolescents. Since only a small proportion of all adolescents with an emotional or behavioral problem receive mental health care (Institute of Medicine 1989; Office of Technology Assessment 1986; Stroul and Friedman 1986), results reported here begin to fill the gap in regard to the paths taken by adolescents to enter public mental health clinics.

Referrals for Mental Health Treatment

The referral process is more coercive for adolescents than adults because of the nature of the former's legal status in American society. Adults can initiate contact with a community mental health center on a more or less voluntary basis unless their participation is the result of a court-ordered mandate (e.g., probation, parole, civil commitment) or an aftercare program following discharge from an inpatient or residential facility. Even when adults are referred by a health professional to a psychiatrist or psychologist, the adult can choose not to follow through on the referral. Adolescents, however, have little choice in the matter; they enter the mental health system primarily because their families or other social institutions decide that their behavior warrants intervention. While others play a role in defining an adult's behavior as deviant, the adult must recognize and, to some extent, accept the label to seek help. For adolescents, however, acceptance of the label is not a part of the referral process. The decision to seek professional help is made by *others* who define the adolescent's conduct as deviant.

Social scientists have long argued that, in addition to psychiatric need, social and psychological factors influence selection into the mental health system (Anderson and Newman 1973; Leaf et al. 1985). For example, labeling theorists believe that an emphasis on individual psychopathology is misguided; rather, an audience must first define behaviors as violating a standard of conduct. Although labeling theory has been

criticized on methodological and theoretical grounds (see Gove 1975), it nevertheless calls attention to the social processes used to define people as rule breakers, and the subsequent application of informal and formal sanctions to deviant behavior. An analysis of the construct of the audience is useful in understanding referrals to community mental health care. The source of a referral can be considered the audience that evaluates an adolescent's behavior as in need of social or therapeutic intervention. A referral is usually made because the adolescent's behavior or emotional problem threatens harm and disruption to some social unit (Mechanic, Angel, and Davies 1991).

Since adolescents lack the legal and social status to make decisions about their own well-being independently of others, several audiences monitor their behavior; these audiences may have different perceptions of the problem behavior. Families may resist seeking professional help for adolescents because they see the behavior as "normal," a problem unrelated to mental health, or stigmatizing (Katz-Leavy, Lourie, and Kaufmann 1987; Sue and McKinney 1975). External agents such as schools and social agencies, on the other hand, may interpret the adolescent's behavior as requiring mental health intervention. While families may be unaware of mental health programs, external agents are likely to know about them.

Referral sources can be conceptualized by their degree of coercion or the formality of the societal response (Rosenfield 1984). As a source's potential to rely on formal sanctions increases, it becomes more coercive (Horwitz 1982). Thus, coerciveness can range from a friend's referral to confinement to a psychiatric hospital by a judge. It should be noted that the degree of coerciveness does not in itself address whether some referrals are more appropriate than others. Coercive referrals may be necessary to insure that an individual receives appropriate mental health services. Coerciveness, however, may have different consequences for the individual. First, an agency referral may result in an individual's stigmatization within the family. A family's referral, on the other hand, may help the individual overcome the stigma associated with seeking mental health care. Second, a family referral may be evaluated differently by mental health professionals than that made by a social agency. Research among adults

suggests that a patient's admission status (e.g., legal status) influences the perception and treatment of patients by staff in the mental health facility (Denzin and Spitzer 1966; Rushing 1978). Finally, some evidence suggests that referrals from an external agency may result in different consequences for the individual than a family referral. Adolescents who are referred into outpatient care from social agencies are more likely to terminate prematurely from treatment and stay in for a shorter time period than are adolescents who enter under more informal circumstances (Bui and Takeuchi 1992).

Rosenfield (1984) argues that those with limited access to power are less likely than high status individuals to seek mental health treatment voluntarily. Accordingly, minority group and poverty status may be strong predictors of coercive referrals. Stehno (1982) has shown that African-American adolescents are more likely than White youth to enter mental health care through law enforcement authorities and less likely to be referred by parents. However, some questions remain about the reasons for minority-White differences in referral patterns. For example, African-American adolescents who enter community mental health care may have a different demographic profile (e.g., younger and poorer) than Whites. On the other hand, a psychiatric perspective would suggest that African-American adolescents are more likely to enter through an external agency because they have more serious psychiatric conditions than Whites (Rosenfield 1984). Thus, it is important to control for other demographic factors and mental health problems to understand more fully the referrals of African-American and other minority adolescents into the mental health system.

To address these issues, we analyzed the means by which minority and White adolescents entered the mental health system in Los Angeles County, one of the largest metropolitan areas in the United States. We investigated two specific issues. First, we assessed whether minority adolescents were more likely than White adolescents to be referred by the family or an external agency. Second, among adolescents who entered the mental health system through an external agency, we examined whether minority adolescents differed from Whites in terms of the type of agency most likely to refer them for public mental health services.

In focusing on the referral of minority adolescents in the Los Angeles County Mental Health System, the present study has one limitation commonly associated with archival data: the infeasibility of examining the social processes involved in referring adolescents for mental health care. Even when referrals are made by an external agent, social negotiations are usually conducted between the agent and family. However, analyses reported in this paper could not address this issue. The data used here were static and reflected the referral source at the time of admission into a mental health clinic. While the data still provided an understanding of largely unknown referral patterns, the inability to comment on process is a major limitation.

Nonetheless, this study is important in documenting in some detail the routes taken by minority adolescents into mental health treatment. This study has two additional unique features. Previous studies have been based on relatively small numbers of ethnic adolescents. Our investigation contained substantial numbers of ethnic minorities. Similarly, while adolescent mental health services have been examined primarily for Whites and, to a lesser extent, African Americans, the present study also included Mexican Americans. Inclusion of these three groups allowed us to assess whether referral patterns were unique to a minority group or whether the patterns were consistent for both minority groups.

METHOD

Data

Data for the study were taken from the Automated Information System (AIS) which is maintained by the Los Angeles County Department of Mental Health. The AIS is designed for management information, revenue collection, clinical management, and monitoring with the potential for research. Data are routinely collected on each client who enters the mental health system in Los Angeles County. Client information is collected on standardized forms by the therapist and then transferred to a computerized file by a clerk. The original data set included 600,000 adult and children who entered a Los Angeles County outpatient, inpatient, day

care, or continuous care facility between 1973 and 1988. Extensive data have been collected on clients, therapists, types of services received, treatment outcomes, and types of agency rendering services.

The county uniformly verifies information related to financial matters. To insure that other data were comparable in quality, six months were spent cleaning the data set. Data-cleaning required cross-checking the data to insure consistency of information (e.g., correspondence of age and birthdate); range-checking to insure that codes were within the field of responses for a particular item; and the omission of duplicate cases. The data were eventually placed into a Statistical Analysis System (SAS) format for use in data analyses. Although reliability and validity are difficult to assess with secondary data drawn from treatment records, these types of data have proven useful in past explorations of minority mental health issues in geographic settings other than Los Angeles (Cheung and Snowden 1990; Hu et al. 1991; O'Sullivan et al. 1989; Snowden and Cheung 1990; Sue and McKinney 1975).

Sample

This study is limited to African-American, Mexican-American, and White adolescents aged 13 to 17 who used outpatient services at a mental health facility in Los Angeles County between January 1, 1983 and December 31, 1988. The original data set was restricted to this five-year period because of inconsistent data definitions and diagnostic criteria for children's disorders prior to 1983. Because the total population of adults and children entering the mental health system during this study time period was quite large (over 100,000 episodes), sampling was initiated to make the data set more manageable. All Asian Americans were included in the initial sampling plan because they comprised only a fraction of the total client population. For the other three ethnic groups, a simple random quota sample was selected. The total number of adults and children sampled for African Americans, Whites, and Mexican Americans each roughly matched the total for Asian Americans. A similar number of episodes (adult and children) from each ethnic group was randomly drawn from the original data set. The final sample of adolescents

reflected approximately the proportion of youth in the total population in each ethnic group.

The following exclusions were made to the data set: (a) adolescents who received no outpatient services but received other types of services such as hospitalization, continuous care, day treatment, or emergency treatment; (b) Asian-American, American Indian, and non-Mexican-Hispanic (e.g., mainland Puerto Rican) adolescents; and (c) any client case that had missing values for any of the measures used in this study. If an adolescent received other types of services in addition to outpatient treatment during the five years, the information pertinent to the outpatient services was included in the analyses. American Indian and non-Mexican-Hispanic youth were excluded because of their small numbers.

After careful consideration, we decided to omit the Asian-American sample from the analyses. Because the data were weighted to reflect the current sample total, Asian Americans would have comprised a small proportion of the sample. Since Asian Americans consist of a number of ethnic groups (e.g., Japanese, Chinese, Korean), separate analyses are planned to explore the diverse referral patterns in this ethnic category.

The unit of analysis here was the first client case during the five-year period. A client case refers to an unduplicated child or adolescent receiving community mental health services. After all of the exclusion criteria were defined, the final sample sizes for clients included 842 African Americans; 956 Mexican Americans; and 662 Whites. Only 36 client cases were eliminated due to missing values.

Measures

The dependent measure used in the following analyses was the source of referral at the time of the adolescent's first admission to an outpatient mental health clinic. The original data for referral source were coded in more than 40 categories. For this particular study, we recoded the referrals into four general categories: (a) *family* (family, self, or friends); (b) *social agency* (probation department, children's services, etc.); (c) *school*; and (d) *health* (other health and mental health professional). A health referral may reflect prior contact with the mental health system.

Since gender, age, and poverty status may help to explain minority-White differences in referral patterns (Briones et al. 1990; Costello and Janiszewski 1990; Stehno 1982), they were included as control variables in subsequent multivariate analyses. Age has a limited range; only adolescents aged 13 to 17 were included in the analyses. Poverty status was measured by the adolescent's eligibility for Medi-Cal, which was determined by gross family income adjusted for the number of dependents in the household. Medi-Cal-eligible individuals have their health and mental health services paid for by the State of California; accordingly, these people were coded as being in poverty. A poverty dichotomy may result in a misclassification of adolescents since some families are just above or below the Medi-Cal cutoff point. The poverty status dichotomy is nonetheless useful because it reflects a socially defined category of people in economic need.

RESULTS

In all analyses, the data were weighted to compensate for the differential probabilities of selection and to make the sample comparable to the population of African-American, Mexican-American, and White adolescents who entered outpatient services between 1983 and 1988. Table 1 displays the characteristics of the 2,460 adolescents included in the study. With the exception of 13-year olds, the sample distribution within each age group ranged between 19 percent and 25 percent. More than one-half (58%) of the adolescents entering the mental health system for their first episode were males. A majority of the adolescents came from poor families. Slightly more than one-half of all referrals came from agencies; about one-quarter of referrals were made by family members.

Ethnic differences were evident among adolescents who entered mental health services, especially between African Americans and Whites. African-American adolescents referred for mental health services were older than Whites—46 percent were aged 16–17, compared to 38 percent of White adolescents. African Americans also had a significantly larger percentage of males than Whites (68% vs. 54%) and a higher percentage in poverty—89 percent vs. 72 percent for Whites. Mexican-American adolescents who received

TABLE 1. Characteristics of the Total and Ethnic Samples (Unweighted Ns and Weighted Percentages)

	Weighted Percentages			
	Total Sample %	African American %	Mexican American %	White %
<u>Age</u>				
13	17	14	18	17
14	20	19	20	21
15	22	22	19*	24
16	21	25*	22	19
17	20	21	20	19
<u>Gender</u>				
Female	42	33**	44	46
Male	58	68	56	54
<u>Poverty Status</u>				
Poverty	79	89**	80**	72
Non-poverty	21	11	20	28
<u>Referral Source</u>				
Family	28	21**	32	28
Social/legal	53	67**	44**	52
School	11	6**	15**	10
Other health	9	6**	9	10
Unweighted N	2460	842	956	662

Note: Some percentages may not add to 100 percent due to rounding. Tests of proportions were conducted between the minority groups and Whites controlling for multiple comparisons. For dichotomous variables (gender and poverty status), only one test is reported.

* $p < .05$; ** $p < .01$.

services tended to be poorer than Whites. All groups were referred most often by an external agency rather than the family. Mexican Americans had the largest percentage of family-referred adolescents than other ethnic groups. African Americans were more likely to enter through a referral from a social or legal agency than Whites. Mexican Americans were more likely than Whites to be referred by the schools.

We now move to assess whether ethnic groups differed in referrals from informal sources (the family) or an external agency (social, school, and health). Two logistic models are presented in Table 2. In each logistic model, a family referral is coded as 1 and others are coded as 0. The beta coefficients are converted to odds ratios and can be read as the expected odds of a family referral. An odds ratio greater than 1 indicates that a variable increases the odds of a family referral, and a ratio less than 1 decreases the odds. In Model 1, ethnic group is the only independent variable; Model 2 adds gender, age, and poverty status as control variables. The baseline group for ethnic comparisons are White adolescents.

In Model 1, African-American adolescents were less likely than Whites to enter the

mental health system through a family referral. Seen another way, African-American adolescents were 1.48 times more likely than Whites (1/.70) to be referred by an external agency. Mexican Americans were more likely than Whites to be referred by the family, but the difference was not statistically significant. Model 2 assesses whether the difference between African Americans and Whites remains when the demographic variables are

TABLE 2. Multiple Logistic Regression Models Estimating the Effect of Ethnic Group on a Family Referral (N = 2,460)

	Model 1 Odds ratio	Model 2 Odds ratio
<u>Ethnic Group</u>		
African American	.70**	.91
Mexican American	1.21	1.34**
White (baseline)	1.00	1.00
<u>Gender</u>		
Female	—	1.89***
Male (baseline)	—	1.00
<u>Age</u>	—	.84***
<u>Poverty Status</u>		
Poverty	—	.42***
Non-poverty (baseline)	—	1.00

— Variable not included in the model.

* $p < .05$; ** $p < .01$; *** $p < .001$.

held constant. While African Americans were still less likely than Whites to enter the mental health system through a family referral, the difference was no longer significant. Instead, other factors appeared to be more important in explaining a family referral. Females, younger adolescents, and adolescents not living in poverty were more likely to be referred by the family than by an external referral source. As noted earlier, African Americans differed from Whites on all three variables. Of the three demographic variables, poverty status had the strongest effect. Adolescents who were poor, regardless of ethnic group, were 2.3 times more likely than the non-poor to enter community mental health care through an external agency (1.42). Model 2 also shows that Mexican Americans were significantly more likely than Whites to be referred by the family when other variables were held constant. Thus Mexican Americans and African Americans seemed to have had different referral patterns.

A third analysis added the adolescent's admission diagnosis to the model. While the diagnosis of children and adolescents has improved tremendously over the past ten years, problems still exist in the assessment of adolescents (Quay 1988). When minorities are involved, cultural and social factors may hinder the proper assessment of an adolescent's behavior. In addition, admission diagnosis may be affected by the conditions under which adolescents enter the mental health system. However, we were curious to see whether the type of mental health problem changed the relationship between ethnicity and a family referral. This analysis (not shown) demonstrated that diagnosis was

associated with a family referral, but did not significantly alter the pattern of relationships among ethnicity, other demographic variables, and family referrals. This finding was consistent in subsequent analysis and thus required no further discussion.

We also examined the interactions between ethnic group and the other sociodemographic variables (analyses not shown). Only poverty status showed a significant interaction with ethnic group in explaining the type of referral. Mexican Americans in poverty were more likely than Whites in poverty to be referred by a family member. Among adolescents who were not poor, Mexican Americans and Whites had a similar proportion of family referrals. No such relationship was found for African Americans.

The next analysis was intended to determine if minorities differed from Whites in the type of external agency making referrals to the mental health system. Accordingly, adolescents who were referred by the family were excluded from these analyses. Table 3 displays three separate sets of logistic regression analyses with each set predicting referrals from a different external source (social agencies, schools, and health agencies). Odd-numbered models had ethnic group as the sole predictor variable and even-numbered models included ethnic group and controlled for gender, age, and poverty status.

In the first set of analyses, African-American adolescents were twice as likely as Whites to come into community mental health care through a referral from a social agency (Model 1). Mexican Americans were significantly less likely to be referred by a social agency. When controlling for the demo-

TABLE 3. Multiple Logistic Regression Models Estimating the Effect of Ethnic Group on Referral Source, Excluding Family Referrals (N = 1,777)

	Social Agencies		School Referrals		Health Referrals	
	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Ethnic Group						
African American	2.10***	1.53**	.52***	.76	.50***	.62**
Mexican American	.72**	.62**	1.65**	1.98***	.97	1.00
White (baseline)	1.00	1.00	1.00	1.00	1.00	1.00
Gender						
Female	—	.43***	—	1.55**	—	2.40***
Male (baseline)	—	1.00	—	1.00	—	1.00
Age	—	1.31***	—	.69***	—	.95
Poverty Status						
Poverty	—	4.65***	—	.22***	—	.56**
Non-poverty (baseline)	—	1.00	—	1.00	—	1.00

— Variable not included in the model.

* $p < .05$; ** $p < .01$; *** $p < .001$.

graphic variables, the odds of a social agency referral was somewhat reduced for African Americans and increased for Mexican Americans, but the differences remained significant (Model 2). The other demographic variables also showed a significant relationship with a social agency referral. Most notably, adolescents who were poor were over four times more likely than the non-poor to be referred by a social agency. Males also were twice as likely as females to enter mental health clinics by a social agency referral.

A different pattern emerged for school referrals. In Model 3, African Americans were less likely than Whites to be referred by a school agency. On the other hand, Mexican Americans were 1.7 times more likely than Whites to be referred by the schools. The relationship remained for Mexican Americans but not for African Americans, when controlling for other demographic variables (Model 4). Again, poverty status was a critical variable in explaining referrals; being poor increased the odds of not being referred by the schools by 4.5.

The final set of analyses assessed referrals from health agencies. African Americans were less likely than Whites to be referred by a health agency (Model 5). Mexican Americans did not significantly differ from Whites in the probability of a health referral. In Model 6, the ethnic pattern of health referrals remained when controlling for gender, age, and poverty status. Females were 2.4 times as likely as males to enter the mental health system through a health agency. While age was not significantly associated with a health referral, the poor were less likely to be referred by a health agency.

Statistical interactions between ethnic group and demographic variables also were examined for each type of referral (not shown). No consistent pattern emerged from this analysis. The most notable interaction occurred when referrals of adolescents by a school agency were examined. Among adolescents who were poor, Mexican Americans were significantly more likely than White adolescents to be referred by the schools. Non-poor Mexican-American and White adolescents did not differ significantly in school referrals.

DISCUSSION

These analyses suggest that African-American adolescents are more likely than Whites to enter public outpatient clinics through coercive means. Since analyses of referrals to private clinicians were not included here, generalizing this finding to non-public mental health settings should be done cautiously. The pattern of coercive referrals appeared to be explained primarily by the fact that African-American youth who entered mental health care tended to be older, male, and poorer than their White counterparts. Once these factors were accounted for, no differences in coercion were found between African Americans and Whites.

These results suggest several possible ways to address the issue of the overrepresentation of African-American adolescents (and adults) in community mental health clinics. First, an obvious selection process occurred in the referral of adolescents to community mental health care. Nearly 80 percent of the adolescents entering the system were poor. In addition, the poor were twice as likely to enter from an external agency and since nearly 90 percent of all African-American adolescents in the community mental health system were poor, this reduced the differences between African Americans and Whites in terms of external referrals. Indeed, when we examined African-American/White differences in the probability of referral from an external source, controlling for age and gender but not poverty (analyses not shown), African-American adolescents were significantly more likely than Whites to enter from external sources.

Second, and related to this first point, is a result shown in other research: African Americans are more likely to be living in poverty than Whites and other groups. Approximately 45 percent of African Americans under the age of 18 are poor, compared to 17 percent of Whites in the same age group (O'Hare 1989). Since 60 percent of all poor households receive some means-tested public assistance such as food stamps, public housing, and free or reduced-fee school lunches (Social Security Bulletin 1988), there is an increased chance that African-American adolescents will come under the surveillance of a loose network of agencies. Once in this network, youth perceived to be in need of intervention from mental health agencies have

a greater likelihood of being referred than those outside of this surveillance. Middle-class families with similar problems are less likely to be identified because they are less likely to be part of an agency network.

Third, African-American adolescents from poor families are less likely to be referred by informal networks because they are disproportionately placed in out-of-home placements. African-American adolescents, especially males, are overrepresented in public and private residential facilities such as juvenile detention centers, shelters, halfway houses, group homes, and training schools (U.S. Bureau of Justice Statistics 1985; U.S. Office of Juvenile Justice and Delinquency Prevention 1983, 1987). Dembo (1988) argues that the discrepancy in placements between African Americans and Whites is not due solely to social class factors but may reflect an institutional bias against African-American males. Thus, African-American males are more likely than Whites to be placed in institutional settings and consequently more likely to be exposed to the scrutiny of agencies, including the community mental health system.

Finally, age helped to explain initial differences between African Americans and Whites in referrals from external agencies or family. Older adolescents were less likely than younger adolescents to be referred by an external agency. Social and legal agencies may be more likely to define the behavior of a younger adolescent as embedded in a social unit rather than to see the adolescent's problem as an individual or mental health problem. Families, on the other hand, may be more willing to define younger adolescent behavior as an individual problem. As adolescents age, families may lose control over them and must rely on social agencies for referrals. More empirical investigations are needed of the role played by age in the referral process.

Unlike African-American adolescents, Mexican Americans in poverty were more likely than Whites in poverty to be referred by the family than by an external agency. This relationship cannot be explored further with the present data. For example, special programs may have been initiated in Mexican-American communities to reduce the stigma of adolescent mental health problems and to encourage the use of the community mental health clinics. Rogler et al. (1989) argue that

programs designed specifically for Hispanic adults can improve significantly the use of community mental health programs. More investigations concerning the effects of ethnic-specific programs on the referrals of adolescents for mental health services are needed to test this hypothesis.

The findings also suggest that minority groups differed in the type of agency making the referral. African-American adolescents entered more often through social agency referrals, and Mexican Americans entered more often through the school system than Whites. These differences remained when controlling for age, gender, poverty status, and admission diagnosis. Adolescents who have mental health problems may receive help from various systems other than the specialty mental health sector (e.g., social, educational, health, recreational, juvenile justice). Because the data set used in this paper was limited to specialty mental health services, we cannot address these other systems of care. It is plausible, however, to suggest that schools are less likely to refer than social agencies because psychological or counseling services are incorporated within their organizational structure. Moreover, schools, in comparison to social and legal agencies, are generally concerned with a limited band of behavior in evaluating normalcy and deviance, especially behaviors associated with academic performance and behavior in the classroom. Social and legal agencies often gauge functioning in the larger community. Accordingly, African-American adolescents' overrepresentation in mental health agencies may be due in part to their disproportionate contact with social and legal agencies and the propensity of social agencies to rely more often on the mental health system than the schools.

Mexican-American adolescents' entry into community mental health care through the school system deserves more detailed investigation. The referral process within schools may be influenced by sociocultural factors. For example, since many Mexican-American adolescents are recent immigrants and experience problems in adjusting to a new society (such as speaking English), school officials may be more likely to judge their behavior as deviant and refer them for mental health services. Conversely, some schools may have bilingual programs that are sensitive to the emotional problems of immigrant children

and, consequently, may accurately identify children and adolescents who are in need of mental health services.

Results reported in this paper suggest that the behaviors of the poor and of African Americans are more likely to be labeled by social agencies as needing mental health services. There is an alternative explanation for this labeling perspective. Those holding psychiatric perspective would argue that social agencies can adequately identify adolescents in need of mental health services. Social agencies act as referrals because barriers or obstacles prevent African-American families from seeking professional help for children who need services. We have opted for a labeling perspective because some of our analyses showed that the differences between the poor and non-poor in explaining a family referral and between African Americans and Whites in explaining a social agency referral remained even when controlling for psychiatric disorder. Thus, social agencies' tendency to refer African-American adolescents and the poor was not explained by the clinical condition of the adolescents. However, better measures of the clinical conditions and other assessments (e.g., the family's attitudes toward treatment and anticipation of stigma, the social agency's perspective of the client's problem) are needed to test more adequately the different hypotheses relating to the labeling perspective.

The issue can be summarized as one of "overpathology" and "underpathology." The provision of mental health services in minority communities can be biased in two opposite directions (Lopez 1989). On the one hand, mental health problems can be "overpathologized" in some minority communities. This context may hold a tendency to diagnose mental or emotional problems as the root cause of "problem behaviors" exhibited by minority adolescents. This tendency may be in error since the behavior may be a normal response to living in adverse conditions such as poverty. On the other hand, mental health problems can be "underpathologized" in minority communities. The empirical literature on minority mental health argues that problems may go unnoticed and that minorities encounter a number of barriers that deter them from using services. Social and cultural factors that prevent minorities from using services include negative attitudes toward

psychotherapy, the shame and stigma of receiving mental health treatment, lack of proficiency in English, and different conceptions of mental health (Marsella 1985; Rogler et al. 1989; Sue and Morishima 1982; Takeuchi, Leaf, and Kuo 1988). Institutional barriers also may deter minorities from using services such as the lack of bilingual and minority therapists and services that are incompatible with the minority group's culture (Child and Adolescent Service System Program 1989; Higginbotham 1987; Sue et al. 1991). As a result, the mental health system has been asked to be more sensitive to the special issues of minorities, and there is an apparent demand to increase the utilization of mental health programs. Both underpathologizing and overpathologizing can prove detrimental, and more research is needed to understand the extent of these biases in different minority communities.

There also is a need to document how the family, social agencies, schools, and mental health systems negotiate the referral of adolescents for mental health care. In addition, more documentation is needed of the reasons for coercive referrals resulting in less utilization and poorer treatment outcomes than other types of referrals (Bui and Takeuchi 1992). These issues are especially critical in light of increased national attention on children and adolescent mental health issues in the past few years. As efforts are made to refer children and adolescents with problems for mental health services, policy makers must be cognizant of the fact that minorities and the poor enter the system in different ways than do Whites, and that the differential pathways may have consequences for treatment and services as well as for treatment outcomes.

REFERENCES

- Anderson, Ronald and John Newman. 1973. "Societal and Individual Determinants of Medical Care Utilization in the United States." *Milbank Memorial Fund Quarterly: Health and Society* 51:95-124.
- Briones, David, Peter Heller, H. Paul Chalfant, Alden Roberts, Salvador Aguirre, and Walter Farr. 1990. "Socioeconomic Status, Ethnicity, Psychological Distress, and Readiness to Utilize a Mental Health Facility." *American Journal of Psychiatry* 147:1333-40.
- Broman, Clifford. 1987. "Race Differences in

- Professional Help Seeking." *American Journal of Community Psychology* 15:473-89.
- Bui, Khanh-Van T. and David T. Takeuchi. 1992. "Ethnic Minority Adolescents and the Use of the Community Mental Health Care System." *American Journal of Community Psychology* 20:403-17.
- Cheung, Freda and Lonnie Snowden. 1990. "Community Mental Health and Ethnic Minority Populations." *Community Mental Health Journal* 26:277-91.
- Child and Adolescent Service System Program. 1989. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: CASSP.
- Costello, Elizabeth and Susan Janiszewski. 1990. "Who Gets Treated? Factors Associated with Referral in Children with Psychiatric Disorders." *Acta Psychiatrica Scandinavica* 81:523-29.
- Dembo, Richard. 1988. "Delinquency Among Black Male Youth." Pp. 129-65 in *Young, Black, and Male in America: An Endangered Species*, edited by J.T. Gibbs. San Francisco: Jossey-Bass.
- Denzin, Norman and Stephan Spitzer. 1966. "Paths to the Mental Hospital and Staff Predictions of Patient Role Behavior." *Journal of Health and Social Behavior* 7:265-71.
- Fried, Marc. 1975. "Social Differences in Mental Health: A Sociological Analysis." Pp. 135-92 in *Poverty and Health (Revised Edition)*, edited by J. Kosa and I. Zola. Cambridge: Harvard University Press.
- Gove, Walter. 1975. "Labeling and Mental Illness: A Critique." Pp. 35-81 in *The Labeling of Deviance: Evaluating a Perspective*, edited by W. Gove. New York: John Wiley and Sons.
- Higginbotham, Howard N. 1987. "The Cultural Accommodation of Mental Health Services for Native Hawaiians." Pp. 94-126 in *Contemporary Issues in Mental Health Services in the Pacific Islands*, edited by A.B. Robillard and A.J. Marsella. Honolulu: University of Hawaii, Social Science Research Institute.
- Horwitz, Allan. 1982. *The Social Control of Mental Illness*. New York: Academic Press.
- Hu, Teh-Wei, Lonnie Snowden, Jennette Jerrell, and Tuan Nguyen. 1991. "Ethnic Populations in Public Mental Health: Services and Level of Use." *American Journal of Public Health* 81:1429-34.
- Institute of Medicine. 1989. *Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative*. Washington, DC: National Academy Press.
- Katz-Leavy, Judith, Ira S. Lourie, and Roxanne Kaufmann. 1987. "Meeting the Mental Health Needs of Severely Emotionally Disturbed Minority Children and Adolescents. A National Perspective." *Children Today* 16(5):10-14.
- Leaf, Philip, Martha Livingston, Gary Tischler, Myrna Weissman, Charles Holzer, and Jerome Myers. 1985. "Contact with Health Professionals for the Treatment of Psychiatric and Emotional Problems." *Medical Care* 23:1322-37.
- Lopez, Steven. 1989. "Patient Variable Biases in Clinical Judgement: Conceptual Overview and Methodological Considerations." *Psychological Bulletin* 106:184-203.
- Marsella, Anthony. 1985. "Culture, Self, and Mental Disorder." Pp. 281-307 in *Culture and Self: Asian and Western Perspectives*, edited by A. Marsella, G. DeVos, and F. Hsu. New York: Tavistock.
- Mechanic, David, Ronald Angel, and Lorraine Davies. 1991. "Risk and Selection Processes Between the General and the Specialty Mental Health Sectors." *Journal of Health and Social Behavior* 32:49-64.
- Milazzo-Sayre, Laura, Paul Benson, Marilyn Rosenstein, and Ronald Manderscheid. 1986. *Use of Inpatient Psychiatric Services by Children and Youth Under Age 18, United States, 1980*. Washington, DC: National Institute of Mental Health.
- Neighbors, Harold. 1985. "Seeking Professional Help for Personal Problems: Black Americans Use of Health and Mental Health Services." *Community Mental Health Journal* 21:156-66.
- and James Jackson. 1984. "The Use of Informal and Formal Help: Four Patterns of Illness Behavior in the Black Community." *American Journal of Community Psychology* 12:629-44.
- O'Hare, William. 1989. "Poverty in America: Trends and New Patterns." *Population Bulletin* 40:1-45.
- O'Sullivan, Michael J., Paul D. Peterson, Gary B. Cox, and John Kirkeby. 1989. "Ethnic Populations: Community Mental Health Services Ten Years Later." *American Journal of Community Psychology* 17:17-30.
- Office of Technology Assessment. 1986. *Children's Mental Health: Problems and Services—A Background Paper*. Washington, DC: U.S. Government Printing Office.
- Quay, Herbert. 1988. "Dimensions of Psychopathology in Childhood and Adolescence." Pp. 33-37 in *Children's Mental Health Services and Policy: Building a Research Base*, edited by P. Greenbaum, R. Friedman, A. Duchnowski, K. Kutash, and S. Silver. Tampa, Florida: University of South Florida.
- Rogler, Lloyd, Robert Malgady, and Orlando Rodriguez. 1989. *Hispanics and Mental Health: A Framework for Research*. Malabar, FL: Robert E. Krieger Publishing.
- Rosenfield, Sarah. 1984. "Race Differences in

- Involuntary Hospitalization: Psychiatric vs. Labeling Perspectives." *Journal of Health and Social Behavior* 25:14-23.
- Rosenstein, Marilyn and Laura Milazzo-Sayre. 1981. *Characteristics of Admissions to Selected Mental Health Facilities, 1975: An Annotated Book of Charts and Tables*. Rockville, MD: U.S. Department of Health and Human Services.
- Rushing, William. 1978. "Status Resources, Social Reactions, and Type of Mental Hospital Admission." *American Sociological Review* 43:521-33.
- Snowden, Lonnie and Freda Cheung. 1990. "Use of Inpatient Mental Health Services by Members of Ethnic Minority Groups." *American Psychologist* 45:347-355.
- Social Security Bulletin. 1988. *Social Security Bulletin: Annual Statistical Supplement, 1988*. Washington, DC: Social Security Administration.
- Stehno, Sandra. 1982. "Differential Treatment of Minority Children in Service Systems." *Social Work* 27:39-45.
- Stroul, Beth A. and Robert Friedman. 1986. *A System of Care for Severely Emotionally Disturbed Children and Youth*. Washington, DC: Georgetown University Child Development Center.
- Sue, Stanley, Diane Fujino, Li-Tze Hu, David Takeuchi, and Nolan Zane. 1991. "Community Mental Health Services for Ethnic Minority Groups: A Test of the Cultural Responsiveness Hypothesis." *Journal of Consulting and Clinical Psychology* 59:533-40.
- and Herman McKinney. 1975. "Asian Americans in the Community Mental Health Care System." *American Journal of Orthopsychiatry* 45:111-18.
- and James Morishima. 1982. *The Mental Health of Asian Americans*. San Francisco: Jossey-Bass.
- Sussman, Linda, Lee Robins, and Felton Earls. 1987. "Treatment-Seeking for Depression by Black and White Americans." *Social Science and Medicine* 3:87-196.
- Takeuchi, David, Philip J. Leaf, and Hsu-Sung Kuo. 1988. "Ethnic Differences in the Perception of Barriers to Help-Seeking." *Social Psychiatry and Psychiatric Epidemiology* 23: 273-80.
- U.S. Bureau of Justice Statistics. 1985. *Census of Public and Private Juvenile Detention, Correctional, and Shelter Facilities*. Washington, DC: U.S. Bureau of Justice Statistics.
- U.S. Office of Juvenile Justice and Delinquency Prevention. 1983. *Children in Custody: Advance Report on the 1982 Census of Public Juvenile Facilities*. Washington, DC: U.S. Office of Juvenile Justice and Delinquency Prevention.
- 1987. *Children in Custody: Census of Public and Private Juvenile Custody Facilities*. Washington, DC: U.S. Office of Juvenile Justice and Delinquency Prevention.

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