JOURNAL OF UNDERGRADUATE SOCIAL WORK RESEARCH

VOLUME I • INAUGURAL ISSUE • 2017

150
ILLINOIS
1867-2017

UNIVERSITY OF
ILLINOIS
SOCIAL WORK
URBANA-CHAMPAIGN

Table of Contents

About the Journal……………………………………………………………………………………..*ii*
Acknowledgements……………………………………………………………………………..*ii*
Staff………………………………………………………………………………………………..*ii*
Letter……………………………………………………………………………………………...*iii*
Preface…………………………………………………………………………………………….*iii*

Scholarly Research

Political and Racial Polarization and Its Intersection with Social Work
*Lilyia Garci*a...1-9

Literature Reviews

Mental Health of Adolescents in Foster Care
Anne Coulomb..*10-20*

A Literature Review Identifying Gaps in Teaching Intersectionality In Higher Education
Kahlia Roe Halpern..*21-33*

The Comorbidity of Diabetes & Depression Among Latinas: A Literature Review
Caroline R. Quintanilla, BSW..*34-50*

Policy Analysis

Illinois Early Intervention Services Systems Act and Potential Return on Investment for Local Agencies and School Districts: A Researched Based Policy Analysis
Lorna Gilmore..*51-59*

About the Journal

The University of Illinois at Urbana-Champaign School of Social Work's annual publication, *Journal of Undergraduate Social Work Research (JUSWR),* showcases peer-reviewed undergraduate research from social work and related disciplines that contribute to the advancement of social and economic justice.

Acknowledgements

We would like to express our gratitude to Dean Wynne Korr for her vision, leadership, and unwavering support of this significant achievement.

We also thank all of the School of Social Work faculty for their encouragement and support shown to the authors of the JUSWR inaugural issue. We further wish to extend a very special thanks to Dr. Karen Tabb-Dina, Emily Athena Lux, Maria Pineros Leano, and Carol Wilson-Smith for their extraordinary mentoring, guidance, and support on behalf of the student authors.

Our sincere thanks go out to Becky Ponder for her graphic design expertise. And last but by no means least, we acknowledge and are grateful to Kahlia Roe Halpern and Joy Sugihara for their contributions to the planning and development of the *Journal of Undergraduate Social Work Research*.

Staff

JOURNAL OF UNDERGRADUATE
SOCIAL WORK
RESEARCH

Letter

Dear Reader,

I am pleased to welcome you to the inaugural issue of the *Journal of Undergraduate Social Work Research (JUSWR).* This journal is a collaborative effort between students, faculty and staff. Undergraduate student editors were highly involved and instrumental in the selection, editing process, and making recommendations for articles to be included in this inaugural publication volume. As Senior Editor, Rebecca Hawley did a fantastic job of working closely with the editorial board to provide expert guidance through the publication process. Faculty members generously gave of their time to mentor students on research and writing. Dr. Janet D. Carter Black played a crucial role as Undergraduate Research Program Coordinator for the School of Social Work. Together, the team worked tirelessly to bring the first issue of the *JUSWR* to fruition.

The *Journal of Undergraduate Social Work Research* is a crucial initiative for the School of Social Work and the University of Illinois at Urbana-Champaign aimed at actively supporting undergraduate research. Student opportunities range from serving as a member of a faculty directed research team or pursuit of their own line of inquiry. They may also choose from options to author a manuscript for publication, serve as a peer editor, or present their work at the annual Undergraduate Research Symposium. Some students elect to receive credit toward the Undergraduate Research Certificate Program offered by the Office of Undergraduate Research. All of them make scholarly contributions that strengthen vulnerable populations and provide support where it is most needed.

I am honored to introduce the inaugural issue of the *Journal of Undergraduate Social Work Research*. It provides abundant proof of the high quality of undergraduate social work research that takes place on the University of Illinois at Urbana-Champaign campus.

Sincerely,

Brenda Lindsey, EdD
BSW Program Director
School of Social Work

Preface

The future of the social work profession depends on our ability to provide the best education for practice. The future of the discipline of social work depends on our ability to engage the curiosity of undergraduates in social work, encouraging critical inquiry through research. I am proud that the University of Illinois at Urbana-Champaign has taken the lead in nurturing undergraduate research.

My thanks to Dr. Janet D. Carter-Black for her unwavering leadership in this effort, and to Dr. Brenda Lindsey for her advocacy to create this journal.

Wynne S. Korr, Professor and Dean
School of Social Work

Scholarly Research

Political and Racial Polarization and the Intersection with Social Work

Lilyia Garcia

University of Illinois at Urbana-Champaign

Immediately following the 2016 presidential election, fifty-one people were given an online survey based on several political topics: race, party identification, voting choice, and opinions on the state of political and racial polarization in the United States. Given the role of the media to shape public opinion, an option was given for the survey respondents to give their opinion on controversial articles that were selected. Before conducting the survey, I believed that the respondents would agree that the United States is polarized, but agree with the message that the controversial articles were giving off. The clear majority of respondents agreed that the United States is becoming more politically and racially divided. I then used their responses for a discussion-based presentation and connected the issue of polarization to social work; social workers must validate the concerns of their clients following the election, but must also teach resiliency.

Keywords: politics, race, polarization, discrimination

Political and Racial Polarization and the Intersection with Social Work

The emergence of social media has made the public more aware of social issues. As with other forms of media, social media has the power to form public opinion and increase the salience of world issues. Furedi (2014) discusses multiple protests, such as Occupy Wall Street, the Arab Spring, and the Hong Kong and Ukraine government resistances. The author elaborates on social media's role in the formation and stability of these protests. While not mentioned in Furedi's article, my presentation mentions the salience of hashtags such as #blacklivesmatter and #notmypresident in shaping public opinion on racial and political issues.

With race being a significant issue in today's political environment, it is often difficult to see where a mixed-race person falls. Mixed-race students are underrepresented at the University of Illinois, as 2 percent of students self-identify as mixed-race (“UIUC…”, 2016). Consequently, respondents’ perceptions of mixed-race individuals were viewed through several conceptual lenses. The first concept was color blindness, the belief that race does not factor into how one makes sense of the world (Lux, 2016). The second concept was color consciousness, referring to the heightened awareness of racial issues and process of confronting the reality of race and racism in the United States (Lux, 2016). Until students are exposed to race education, they may operate from a color-blind view of society (Rosenblum & Travis, 2012). If it can be implied that most who took the survey were concurrently enrolled in a particular diversity course, it can be inferred that most students or survey respondents might have adopted a more color conscious view of society. It was initially hypothesized that most respondents’ estimations of the percentage of UIUC students who identify as mixed-race would be considerably higher than the actual percentage. This was shown to be the case in the results.

The following questions were only asked of the presentation audience in order to connect race perception with mixed-race individuals: Why was there such a large difference in people’s perceptions of the number of mixed-race individuals on the UIUC campus? Are we more color blind than color conscious if we fail to see these differences in race? Do mixed race individuals feel that they need to choose to identify as one race over the other? These questions were connected to concepts of assimilation and acculturation. According to Carter-Black and Pineros (2016), assimilation is defined as relinquishing one’s original culture in favor of the norms and behaviors of the dominant culture while acculturation is defined as the blending of elements of two or more cultures including aspects of the dominant culture. It can be argued that the failure of the respondents to acknowledge these differences amongst mixed-race individuals is in direct contrast to being a color conscious individual.

Next, in the wake of the election results, tensions were high across the country. Many people responded negatively to the election of Donald Trump as president of the United States. This presentation aimed to encourage participant dialogue about the election outcome, which was a challenging task. One side argued that negative feelings were a result of increased sensitivity to world issues. Another side argued that the negative feelings were valid given the unique circumstances of President Trump's election. Given the position of the National Association of Social Worker's Code of Ethics, there is no right or wrong position to this argument for social workers.

> Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability. – NASW Code of Ethics, 6.04 ("Code of Ethics…" 2008).

In the final analysis, most respondents believe that the United States is politically and racially divided. The polarization represented by the opposite ends of this political spectrum could potentially lead to more deeply entrenched racism and discrimination. As future social workers or those with an interest in social work, we need to be cognizant of and identify ways to address the polarization issue and make sure clients of all backgrounds have a safe space to express their concerns. Many people are dissatisfied and greatly concerned about the election results. Their concerns are valid, but we must also promote resiliency and emphasize the strengths perspective. Alienating individuals for their beliefs does nothing for the overall welfare of society. These are difficult issues to talk about, but they are issues that should be talked about.

Methods

Participants

A total of 51 anonymous respondents completed an online survey (except for one duplicate entry that was later removed from the spreadsheet). Participation in the survey was voluntary, and the survey was sent out through multiple means such as text message, Facebook, and GroupMe. As this was not a true random sample, the demographics of the respondents were skewed toward the demographics of the University; mostly white and seemingly with a liberal slant.

Materials

The survey was administered via Google Forms, an online survey service provided by Google. It consisted of eight mandatory quantitative questions on race, voting choice, party alignment, opinion on political polarization (with an option to elaborate on the answer), opinion on racial polarization (with an option to elaborate on the answer), how society should view race, a question on mixed-race individuals, and a question on how they feel about Donald Trump being elected as president of the United States.

The remaining two qualitative questions were optional and asked for the respondent's opinion on two controversial articles. The first selected article was from *The Washington Post*, titled "It's time to stop talking about racism with white people." Linly, the author, discusses their frustrations with how white people react to racial issues (Linly, 2016). The next selected article was from *Mic,* titled "I want a divided America." Subsequently, Cheney Rice discusses their frustrations with supporters of Donald Trump and offers insight into their actions (Cheney Rice, 2016). Both articles have controversial titles and presents controversial opinions, which is why it was deemed essential to include these publications in the survey. There was a less than desired number of responses to the qualitative questions (9-14 out of 51 total responses), but the responses proved to be important to include in the presentation.

Presentation

The information gathered from the survey was used in an informal discussion-based presentation designed to fulfill a James Scholar Program honor course requirement. At times, perceptions do not match behavior. The primary goal of the presentation was to see if the audience's perceptions of race differed from the survey data, to contrast their perceptions to the current political climate, and encourage a positive non-biased discussion on race and politics. Additionally, the audience was given questions that survey respondents were not given to distinguish the presentation from the survey, as discussed in the introduction section. Without questions proposed to the presentation audience, the presentation would have just been a recapitulation of the survey data.

Results

Taking into account the mixed-race individuals and individuals that selected "other" as a race, the sample size was 64.7 percent white, 21.6 percent Hispanic/Latino, 3.9 percent African American, and 19.6 percent Asian/Pacific Islander. The data showed 39/51 voted for Hillary Clinton, 7 voted for Donald Trump, while 5 did not vote. Additionally, 36 identified as a Democrat, 5 identified as independents, 4 were unsure of their political alignment, 3 identified as moderates, and 3 identified as Republicans. Further, 46 thought that this country is experiencing political polarization, 3 said the country might be experiencing political polarization, and 2 said that the country is not experiencing political polarization. While 37 thought that the country is experiencing racial polarization, 13 said that the country might be experiencing racial polarization, and 1 said that the country is not experiencing racial polarization.

The next question asked if society should be color blind or color conscious with no elaboration on what either of these two terms mean. Forty-two (42) said society should be color conscious, and 9 said that society should be color blind. In order to link to the previous question, the next question asked the respondent to give an estimate of the percentage of mixed-race students currently enrolled at UIUC. Most respondents (18) believed that the percentage was between 20-35 percent. In fact, only 2 percent of UIUC students identify as mixed race ("UIUC…", 2016). Next, 62.7 percent of respondents were dismayed about the presidential election of Donald Trump. These results only account for the responses to the quantitative questions. Responses to the qualitative questions can be found in the supplemental documents (Garcia, 2016).

Discussion

Based on survey results, it appears that respondents believe there is a high degree of political and racial polarization in this country. Respondents were more certain about the political division, but less sure about the racial division by a margin of approximately 20 percent. Perhaps if the sample had included a higher percentage of minority students, the data would have indicated more certainty of a racial division in the United States. Nonetheless, the written responses suggest a positive outlook toward the future of race and politics, as represented by the following quote stating:

> ". . . I would love to never hear [that] white people are racist again, I believe racism and injustice still needs a spotlight shone upon it in this country. I believe that white people should be talking to other white people . . . we should all be listening to the people of color around us . . .being told that white people are racist feels like a personal attack, and thus makes me want to discontinue the conversation . . . [but] it is important for . . . black and other voices of color to be

> heard, and if the people of color in our society need to take a break from making their voices heard, then it should be our turn to speak on their behalf as they are willing to let us" (Garcia, 2016).

Other responses were similar to the one above. While respondents understood that there may have been political and racial divisions, it would not serve any useful purpose to exclude the voices of racially privileged groups from conversations on race. Doing so would only foster further alienation, something that social workers should not be promoting. If we can imply that most individuals who voluntarily chose to complete the survey were university students and possibly social work students, the results demonstrate a positive outlook toward acceptance of differences in ideology. While most believe that the country is politically divided, social workers can continue to promote and encourage the creation of a positive and accepting environment, and work to end pointless and ultimately detrimental divisiveness.

To view the PowerPoint presentation with supplemental data, click on the following link.

https://uofi.box.com/v/politicalracialpolarizationppt

References

Carter-Black, J. & Pineros, M. (2016). Assimilation, acculturation, enculturation [PowerPoint slides]. Retrieved from http://compass2g.Illinois.edu

Cheney Rice, Z. (2016, October 14). I want a divided America. Mic. Retrieved from https://mic.com/articles/156802/forget-about-unity-donald-trump-and-his-supporters-need-to-be-shamed-out-of-public-life#.zZEjEBBV1

Code of Ethics of the national association of social workers. (2008). National Association of Social Workers. Retrieved from https://www.socialworkers.org/pubs/code/code.asp

Furedi, F. (2014). How the internet and social media are changing culture. Aspen Institute. Retrieved from http://www.aspeninstitute.cz/en/article/4-2014-how-the-internet-and-social-media-are-changing-culture/

Garcia, L. (2016). Political & racial polarization survey (responses) [Data set, Graphs]. Retrieved from https://docs.google.com/forms/d/1jH5EcfBcSNoC76HWc4ED2G59KyrPzqdzyav2Jtufdi 0/edit?usp=sharing

Linly, Z. (2016, September 7). It’s time to stop talking about racism with white people. Washington Post. Retrieved from https://www.washingtonpost.com/posteverything/wp/2016/09/07/its-time-to-stop-talking-about-racism-with-white-people/?utm_term=.c3dc6e91486f

Lux, E. (2016). Historical trauma [PowerPoint slides]. Retrieved from http://compass2g.Illinois.edu

Rosenblum, K., & Travis, T. (2012). The meaning of difference: American constructions of race, sex and gender, social class, sexual orientation, and disability. McGraw Hill.

UIUC on-campus student enrollment by curriculum, sex, race/ethnicity, and residency. (2016, September 9). Retrieved from UIUC Division of Management Information website: http://dmi.illinois.edu/stuenr/#race

Literature Reviews

Mental Health of Adolescents in Foster Care: A Literature Review

Anne Coulomb
University of Illinois at Urbana-Champaign

This paper examines the mental health of adolescents in the child welfare system and appropriate interventions to address their needs. Rates of mental illness among adolescents in the child welfare system are higher than those in the general population of the same age cohort. Currently, most adolescents are only screened for trauma exposure and symptoms during an assessment after a reported instance of abuse or neglect. The Illinois Department of Child and Family Services utilizes a community based approach that allow at risk children to stay in their home community and use preexisting resources for treatment. Each child receives an individualized treatment plan that focuses on their strengths as well as the strengths of their community. These children have experienced stressful events, potentially including foster care placement. Cognitive based compassion training (CBCT) has the potential to help address such trauma based stress. This intervention helps adolescents learn to regulate their emotions and manage stress which could reduce effects of chronic stress. Finally, treatment foster care (TFC) is also considered as a viable intervention. Treatment foster care provides children with access to individual and family therapy, placement with foster parents who have been trained and screened, and services that extend beyond their time in foster care. In order to remedy the common problem of adolescents with mental illnesses who have not received more comprehensive treatment, a holistic approach with continuous screening is recommended. Elements of this approach are explored in this article.

Keywords: foster care services, youth, mental illness

Mental Health of Adolescents in Foster Care

In the United States, there are 400,000 children in foster care placements on any given day (Scozzaro & Janikowski, 2015). Unfortunately, foster care placement is a relatively common experience for many children across the nation. This statistic does not cover the thousands of families who are involved with child protective services before or after foster care placement has occurred. Annually, there are over three million reports of child maltreatment (Gonzalez, 2014). This includes instances of neglect, physical abuse, psychological maltreatment, and sexual abuse. Child abuse and neglect can be defined as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation of a child," (Gonzalez, 2014, p.8). If these claims of maltreatment are substantiated, child protective services intervenes in order to make sure children and adolescents will be provided with a safe and stable environment that fosters the development of healthy relationships with appropriate role models. Abuse alone is a traumatic experience. However, it can be equally as traumatic for the child to be removed from their home. This can be the case even when placement is the most viable option to ensure the child's safety. Research has shown that children in foster care have higher rates of mental illness when compared to the general population (Scozzaro & Janikowski, 2015; Stoner et al., 2015). This paper examines the mental health of adolescents in foster care and a few appropriate interventions.

Literature Review

Research indicates mental illness is prevalent in 40 percent to 60 percent of foster care youth. (Scozzaro & Janikowski, 2015). Such large-scale occurrences demand access to and implementation of effective evidence-based interventions. Adolescents struggling with trauma and mental illness need supportive services. However, it is reported that 50 percent of children in foster care identified as needing mental health treatment fail to receive services (Scozzaro & Janikowski, 2015). This study further states that many state child welfare systems do not screen children for trauma exposure and symptoms beyond the initial assessment following an abuse or neglect event. The reason mental health services are not provided in a timely fashion could be due in part to the possibility that case managers or caregivers may not immediately see signs indicating the need for such help. It is a mistake to think that since a child does not appear to have symptoms of trauma around the time of the event that they will not surface at a later date. According to Scozzaro and Janikowski, child services should routinely look for trauma symptoms, mental illness, and other related issues in order to ensure at risk adolescents receive the help they deserve (2015). Out-of-home placement decisions are based on what is deemed necessary for the child's immediate safety and well-being (Scozzaro & Janikowski, 2015). Therefore, it is crucial that their mental and emotional needs are taken into consideration as fundamental components of their overall well-being.

According to a study by Greeson et al., (2011), when an adolescent is exposed to multiple forms of trauma by their caregivers, they are said to have experienced complex trauma. In this study, physical abuse, sexual abuse, emotional abuse, neglect, and domestic violence were identified as the five forms or types of trauma. Above authors stated complex trauma occurs when a child experiences two or more of these forms of child maltreatment. In this study, researchers found that out of 2,251 youth in foster care ranging in age from 0 to 21 years, 70.4 percent had experienced at least two forms of trauma. Of the youth studied, approximately 263 or 11.7 percent had experienced all five. These traumatic experiences are typically what precipitates foster care placement. It is expected that one would experience negative responses and associated symptoms to such events. However, these symptoms can be exacerbated by the sense of loss and separation that comes with being removed from one's home. It is crucial that the trauma is addressed by those caring for at risk adolescents in addition to focusing on behavioral and emotional reactions. The authors suggest that when trauma history, trauma-specific reactions, and challenges to functioning caused by the trauma are examined it is easier to obtain services for children that will address many of their needs. In this sample, 83 percent of the individuals were diagnosed with at least one clinical diagnosis, which illustrates the prevalence of mental illness in this population (Greeson et al., 2011). Mental health services should be comprehensive enough to go beyond reactions and symptoms. It is clear that there is a need for youth in foster care to be connected with viable treatment services.

Mental illnesses that frequently occur among those in foster care include depression and posttraumatic stress disorder (PTSD) (Reddy et al., 2013; Stoner et al., 2015). The lifetime prevalence rates of PTSD for individuals in the child welfare system are similar to those of US military veterans (Reddy et al., 2013). Other issues such as substance abuse, personality disorders, mania, and oppositional defiant or conduct disorders are also quite prevalent (Gonzalez, 2014; Reddy et al., 2013). According to Stoner et al., (2015), depression is one of the most commonly diagnosed disorders for youth in the foster care system with an occurrence rate three times that of the general population of the same age cohort. These outcomes may be the result of many factors. For example, these adolescents may be vulnerable due to a genetic predisposition for mental illness. Also, when a child is removed from their home, it may be expected that they will experience feelings associated with significant loss; loss of parent(s), other family members, and community that feels like home. Multiple placements and conflicts with foster family members can also create significant distress. This article further states that there are many studies that support the relationship between depression and child maltreatment (Stoner et al., 2015).

Mental illness among the foster care population is a cause for concern because of the potential impact it can have in various other areas of the young person's life. Without adequate treatment, these individual may become more susceptible to substance abuse, educational failure, juvenile delinquency, homelessness, or incarceration in adulthood (Gonzalez, 2014). Compounding difficulties such as these can make the successful transition to adult life more challenging. Unfortunately, these are not uncommon occurrences for people who have gone through the child welfare system. Twenty-two percent (22 percent) of those who have exited the system report becoming homeless between the ages of 18 to 24 compared to 6.8 percent of those in the general population (Reddy et al., 2013). They also have lower rates of high school graduation and earning a bachelor's degree. It is incumbent upon the child welfare system to provide children and youth with the necessary tools to be functional and achieve success. It is clear that the system of care for children and youth needs make certain better interventions are put in place.

In 2002, the State of Illinois Department of Children and Family Services implemented a community-based program to provide services to children in foster care (Stoner & Fuller, 2015). This program identified the community as the center of the service delivery system and advocated for community-based placements. The program uses several services that already exist within each community and other supports that a child may already be receiving in the area. The Department of Children and Family Services is supposed to focus on reunification of the child and their family. Consequently, this new program is family-centered. Every client has an individualized program that was designed to emphasize their unique strengths and their culture.

According to the study by Stoner and Fuller, (2015) this program has had positive mental health outcomes. As mentioned earlier, it can be traumatic for a child to be removed from everything they know. Therefore, a community-based placement seems to be the most viable option to help retain some sense of normalcy in the child's life. This program also focuses on the individual, which means that their unique needs should be met.

Some professionals use cognitive-based compassion training (CBCT) as a way to help adolescents in foster care learn coping techniques that can help them manage stressors in their lives. CBCT teaches compassion and empathy with a long-term goal of acceptance and understanding of others (Reddy et al., 2013). This intervention has been shown to be effective in teaching stress management and other coping strategies. According to this study, participants age 13 to 17 experienced no difference in terms of psychosocial functioning between their baseline and the end of treatment. However, participants found CBCT helpful in regulating emotion, managing stress, and exhibiting more considerate responses to other people. All 71 participants were surveyed following their experience with CBCT, and 87 percent said they would recommend CBCT to a friend. Approximately 63 percent said that they found it helpful. If adolescents found this treatment beneficial enough to recommend it to others, perhaps this strategy may help reduce barriers to treatment. Mental health services can be stigmatizing, especially so at the ages of 13 to 17. Perhaps having peers who also make use of these services may further help reduce the associated stigma. While this method seems to have the potential to help prevent long-term effects of chronic stress, it should not be the sole treatment adolescents in the foster care system receive. There are many types of stressors associated with entering and remaining in foster care, as well as stressors that come with being a teenager. CBCT could be a beneficial addition to mental health care for adolescents in general, but specifically for those in foster care.

An alternative program was created for adolescents with severe emotional or behavioral disorders who were at risk for placement in group home settings or incarceration as a result of chronic delinquency. Not every young person in foster care faces these issues, but there are components of this program that could be beneficial to all adolescents and their foster families. The Treatment Foster Care (TFC) program was created by the Oregon Social Learning Center to reduce the need for more restrictive residential treatment, which tends to isolate clients (Moore & Chamberlain, 1994). TFC was designed to address the needs of more specialized cases as well as abused and/or neglected children. Targeted clients are placed in a family home, receive out of home care, and attend local public schools. Those interested in becoming foster parents for this client population are required to undergo a screening process to demonstrate their readiness and capacity to create a stable environment and a willingness to work toward helping the youth achieve specific behavioral goals. Once approved, the foster parents must attend 20-30 hours of pre-service training to learn how to set clear limits, address developmental issues, use effective praise techniques, and administer positive consequences.

The TFC program strives to create a foster home environment where the foster parents are equipped to deal with the various struggles they may face while caring for their foster child. There are support groups for foster parents and home consultations to make sure everything is going well with the placement. Adolescents receive individual therapy, and are assigned an advocate who helps them negotiate changes in their programs at school and in the home (Moore & Chamberlain, 1994). Clients also have access to individualized support 24 hours a day so there is always someone there to provide such support. TFC emphasizes family reunification, so an important program component is biological family therapy and home visits to make sure changes can be implemented, such as improved communication and appropriate punishments. Home visits with the biological family gradually increase from one hour to weekends or longer in order to gradually ease families back into the reunified family routine. Additionally, the adolescent's support system continues after they leave the foster home. The TFC program provides 24-hour crisis intervention, support groups, therapy, school-based interventions, and even covers transportation costs on an as needed basis.

As mentioned earlier, it is common for individuals between the ages of 18-24 years old who have exited the foster care system to become homeless. Aftercare services like those available through the TFC and other such programs could make a significant difference in whether or not an adolescent will experience a successful transition into adulthood once they exit the child welfare system.

Based on this review of the research literature one might conclude the most effective way to address the mental health needs of adolescents in foster care is a holistic approach that combines multiple compatible interventions. The Illinois Department of Child and Family Services' community-based program exemplifies a more holistic treatment approach because it emphasizes the benefit of keeping children in their own community and making use of preexisting community-based services. When a child is placed in a foster home, everything they are familiar with could be taken away. This experience has the potential to exacerbate what is arguably highly traumatic in and of itself. If youth are able to remain in their home community, some sense of normalcy may be retained, for example attending the same school. The reasons for foster care placement, and indeed the entry of a child into the foster care system alone is likely to produce significant stress. Cognitive based compassion training could prove to be a valuable strategy to aid in teaching effective coping techniques. Also, the implementation of signature aspects of treatment foster care (individual and family therapy, specialized training for foster parents, and aftercare services), could be incredibly useful in efforts to further improve services provided by the child welfare system.

Children deserve to lead a healthy, happy, and successful life. In order to do so, a range of skills is required. Systems of care should focus on the specific needs of each individual child. If the system of care encompasses a variety of treatment interventions, service providers would be able to select from viable options tailored to meet the specific child's needs. Furthermore, it is crucial that at risk children are regularly screened for symptoms of mental illness and symptoms of trauma. For some, the development of these disorders emerge over time. Therefore, ongoing assessments are critically important. It should be an overarching goal that children and youth exit the child welfare system as close to the normative developmental level of functioning as possible, certainly functioning higher than they were upon entry into the system. In order to achieve such a goal, mental illness, trauma, and stress cannot be ignored. Rather it must be appropriately and responsibly addressed.

Conclusion

Mental illness is a common problem among adolescents in foster care. It is not uncommon for many youth to be unable to access the services that they need. Oftentimes children are only screened during their initial assessment following an abuse or neglect event. The Illinois Department of Child and Family Service's community-based approach, cognitive based compassion therapy, and the Oregon Social Learning Center's treatment foster care programs were examined in this literature review. A holistic approach seems most needed to adequately address mental health concerns of adolescents in the child welfare system. Such an approach would be community based to retain a degree of normalcy in the child's life as well as utilize preexisting resources and services. It would include teaching healthy coping strategies, individual and family therapy, specialized training for foster parents, and aftercare services so that adolescents will continue to feel supported once they exit the foster care system. Adolescents should leave the foster care system better off than when they entered, which requires various treatment and program components to ensure their success.

References

Gonzalez, M. J. (2014). Mental Health Care of Families Affected by the Child Welfare System. *Child Welfare*, 93(1), 7-57.

Greeson, J.P., Briggs, E.C., Kisiel, C.L., Layne, C.M., Ake III, G.S., Ko, S.J. & Fairbank, J.A. (2011). Complex Trauma and Mental Health in Children and Adolescents Placed in Foster Care: Findings from the National Child Traumatic Stress Network. *Child Welfare*, 90(6), 91-108.

Moore, K.J. & Chamberlain, P. (1994). Treatment foster care: Toward development of community-based models for adolescents with severe… *Journal of Emotional & Behavioral Disorders*, 2(1), 22.

Reddy, S., Negi, L., Dodson-Lavelle, B., Ozawa-de Silva, B., Pace, T., Cole, S., & Craighead, L. (2013). Cognitive-Based Compassion Training: A Promising Prevention Strategy for At-Risk Adolescents. *Journal of Child & Family Studies*, 22(2), 219-230. doi: 10.1007/s10826-012-9571-7

Scozzaro, C., & Janikowski, T. (2015). Mental Health Diagnosis, Medication, Treatment, and Placement Milieu of Children in Foster Care. *Journal of Child & Family Studies*, 24(9), 2560-2567. doi: 10.1007/s10826-014-0058-6

Stoner, A., Leon, S., & Fuller, A. (2015). Predictors of Reduction in Symptoms of Depression for Children and Adolescents in Foster Care. *Journal of Child & Family Studies*, 24(3), 784-797. doi: 10.1007/s10826-013-9889-9

Identifying Gaps in Teaching Intersectionality in Higher Education: A Literature Review

Kahlia Roe Halpern

University of Illinois at Urbana Champaign

This literature review aims to examine the available literature and teaching methods regarding the use of intersectionality as an educational and professional tool within undergraduate social work education. Depicted within is an exploration of the historical use of Diversity in Social Work Educational Standards, the origin of intersectionality as a theory, as well as frameworks by which intersectionality acts as an educational and professional enhancement. Critical thought, safe discussion, and community engagement are investigated as methods of increasing intersectional usage. Intersectionality is approached in a qualitative manner where experiences precede statistics to explain impact, highlighting the individual experience within the larger group or system.

Keywords: social work education, intersectionality, intersectional, identity, oppression, and privilege

Introduction

Intersectionality, hailing from feminist theory and frameworks, is understood as the network of identities that formulate and determine experiences of both oppression and privilege within a given society (Combahee River Collective, 1977; Smith, 1987; Crenshaw 1989). As such, intersectionality practices are demonstrated when the interwoven nature of different identity categorizations are applied to the understanding of a person’s experiences and behavior, thereby potentially enhancing informed professional practices as well as the actualization of personal actions (hooks 1981; Lorde 1984; Minha, 1998). Specifically, within the profession of social work, intersectionality could be utilized as a method of practice, by which professionals alter their behaviors to resist perpetuating oppressive occurrences within a client’s life (Hulko, 2009; Jones, 2013; Mattsson, 2014). Comparatively, as an educational tool, future social workers undergo training in which they are taught to apply an intersectional perspective as a preventative measure to avoid oppressive behavior due to the lack of understanding between the client and the worker's experiences (CSWE EPAS, 2008). However, teaching intersectionality in higher education, such as in undergraduate social work programs, is rarely discussed in empirical research and literature about such areas of study (Robinson et al., 2015). As intersectionality can be taught as a method of thought that better prepares individuals for understanding diverse and vulnerable populations, addressing and representing the theory of intersectionality is an important factor in progressing higher education practices.

The values of intersectional education are built upon the idea that individuals are unique and therefore, no single answer can exist as to what is the defining feature within oppression or privilege. Given the vast range of cultures, religions, family structures, and other identities, understanding a person's situation must be considered using the multiple systems in which they operate. These ideas are significant as they bring to light the serious effects underlying or unconscious assumptions have on experiences. An example of the significant impact underlying assumptions have, generalizing an experience of social injustice, such as race inequality, to an overarching identity group, invariably misses the potential privileges and oppressions generated within the individuals of the group. In terms of gender and sexual orientation at the intersection of race, one's racial identity may be differently perceived and experienced due to the various challenges those who are not male or heterosexual face. When missing perspectives occur, diversity amongst groups is at risk for generalization and continuous issues. Thereby promoting that intersectionality is an interesting educational piece that helps encourage critical thinking and comprehensive understandings.

CSWE Mandate

Since the late 1960s, social work education and profession have undergone dramatic transformations in regards to "environmental, demographic, and theoretical developments" (Jani, Pierce, Ortiz, Sowbel, 2011, p. 283). Due to the United States population increase in diversity (U.S. Census Bureau, 2009; as cited in Jani, Pierce, Ortiz, Sowbel, 2011, p. 283), perspectives and attitudes concerning gender, sexuality, ability status, and age (Harper-Dontron & Lantz, 2007; as cited in Jani, Pierce, Ortiz, Sowbel, 2011) began to change, influencing new developments in Social Work education and research (Adams, LeCroy, & Matto, 2009; Fawcett, Featherstone, Fook, Rossiter, 2000; Fook, 2002; as cited in Jani, Pierce, Ortiz, Sowbel, 2011). This led to the introduction of evidence based practice and the need for complex education. In 1971, the Council on Social Work Education (CSWE), approved the addition of Standard 1234 which mandated social work programs to be conducted without discrimination based on "race, color, creed, ethnic origin, age, or sex" as well as to exhibit the efforts made to enhance the program by providing diversity within students, faculty, and staff (CSWE, 1971; as cited in Jani, Pierce, Ortiz, Sowbel, 2011). Upon the confirmation of Standard 1234, Standard 3201, was introduced alongside Affirmative Action policies. Standard 3201 required that students be admitted without discrimination "on the basis of race, color, creed, ethnic origin, age, or sex" (CSWE, 1971; as cited in Jani, Pierce, Ortiz, Sowbel, 2011). Given increases in social work education diversity, Standard 1234A (CSWE, 1973; as cited in Jani, Pierce, Ortiz, Sowbel, 2011) was introduced to modify Standard 1234 which promoted the concept of a "receptive milieu for minority group students and faculty" (Jani, Pierce, Ortiz, Sowbel, 2011, p. 286) which specified that schools must both continue to enhance the presence of diverse peoples in all areas of instruction and to provide educational supports. However, Standard 3201 was loosely defined which led many programs to focus on diversity practice within areas of "academic advising, student retention programs, the nature of field placements, and the demographic composition of field instructional staff" (Jani, Pierce, Ortiz, Sowbel, 2011, p. 286) rather than on producing diverse educational tools and teachings.

While Standard 1234A's purpose was to "achieve the incorporation of knowledge of racial, ethnic, and cultural groups, their generic components as well as differences in values and lifestyles, and the conflicts these generate in the configuration of American Society" (CSWE, 1973; as cited in Jani, Pierce, Ortiz, Sowbel, 2011), it failed to identify the subjectivity of knowledge, the complexity of culture, and the developing roles individuals of color had within the United States society (Jani, Pierce, Ortiz, Sowbel, 2011, p. 286). In 1982, anti-social service politics and second wave feminism influenced the additions of women, age, religion, ability, sexuality, and culture to non-discrimination and educational purpose clauses (CSWE, 1982; as cited in Jani, Pierce, Ortiz, Sowbel, 2011). In conjunction with expanded non-discrimination definitions for overall programs throughout the 1990s, education content, practice scope, and professional development expectations were placed upon graduate level instruction but did not include undergraduate education (Jani, Pierce, Ortiz, Sowbel, 2011, p. 290). In 2008, Educational Policy and Accreditation Standards (EPAS) of CSWE, required diversity within Social Work programs—both graduate and undergraduate—to develop competencies by utilizing and recognizing the interconnecting relationships between culture, oppression, marginalization, and alienation of persons (CSWE EPAS, 2008; as cited in Jani, Pierce, Ortiz, Sowbel, 2011). These standards allowed for self-awareness, personal biases and values, and the ways in which they may affect professional practice (Jani, Pierce, Ortiz, Sowbel, 2011, p. 291).

Intersectionality Defined

Intersectionality addresses the issues in understanding the ways an individual's existence within "multiple socially constructed categories," "affects one's lived experiences, social roles, and relative privilege or disadvantage" (Jones, 2013, p. 101). The intricacy of "power structures and their influence on varying social identities allow the individual to be envisioned as uniquely identified rather than grouped or categorized" (Hankivsky and Cormier, 2011; Murphy, Hunt, Zajicek, Norris, and Hamilton, 2009; as cited in Jones, 2013). Categorization typically refers to the socially constructed groupings, unnatural associations of feature and behaviors, of individuals within their social context which are then taught to hold permanent and significant meaning. Socially constructed categories include areas such as race, gender, or sexuality which contain specific structures and sets of "interconnected social practices" that are both embedded into society as well as enacted by individuals. For example, through a person's given agency, schemas, and resources (Haslanger 2012, pp. 20–23 and pp. 413–418; as cited in Jones, 2013, p. 100), social practices such as gendered bathrooms or sectioned stores, shape the perception of fix identities and their importance for societal function (Haslanger, 2012, p. 463, as cited in Jones, 2013). However, the intersectional approach attempts to deconstruct the various social categories professionals and students may operate within to challenge perspectives that may better serve diverse populations.

Intersectionality is the “metaphorical state of being, primarily in the consciousness of theorists...” (Crow, 1996; Essed, 1991; Mama, 1995; Marks, 1999; Millar, 1998; Morris, 1996; Shakespeare, 1996; Smith, 1987; as cited in Hulko, 2009, p. 48), as it is a paradigm in which certain frameworks and lens must be capitalized upon to understand the network of identities influencing experience properly. “Social Location” (Hulko, 2009, p. 45), is the result of interacting with intersectionality. Thus, “Social Location” is one’s placement amongst interlocking oppressions that provides an individual with the perception of their surroundings in the context of its changed value within their current setting Hulko, 2009, p.45). Concerning malleable identities such as race, ethnicity, social class, gender, sexual orientation, age, or disability, viewing “intersectional beings holistically rather than try[ing] to tease apart different strands of identity” (Andersen & Hill Collins, 2001; Bannerji, 1995; Brah, 2001; Brah & Phoenix, 2004; Crenshaw, 1994; Lorde, 1984/2007a; Mullaly, 2006; as cited in Hulko, 2009) produces the intersectional state of being in the context of one’s social location.

Intersectionality as Enhancement of Student Education

Critical social workers and researchers agree that the practice of social work should be driven by “challenging inequality, marginalization, and oppression at a structural level” with application of the intersectional understanding of social issues (Adams, Dominelli, & Payne, 2002; Bailey & Brake, 1975; Dominelli, 2002; Pease & Fook, 1999; Sakamoto & Pitner, 2005; as cited in Mattsson, 2014). This perspective arose as a criticism of traditional social work for upholding and supporting the experiences of oppression as independently enacted and unique to the individual (Mattsson, 2014, p.8). As critical and radical social work approaches to oppression and inequality are popularized, a need for “usable tools for critical practice” is demonstrated amongst professionals (Mattsson, 2014, p.9). Critical reflection aims to bring knowledge of social structures and their effects on social work practice (Brookfield, 2009; Dominelli, 2002; Fook, 2002; as cited in Mattson, 2014) by assisting professionals in developing an awareness as to how their practices may perpetuate experiences of oppression onto their clients through unconscious thoughts, feelings, and assumptions in everyday operation (Essed, 1996; Young, 1990; Hulko, 2009; as cited in Mattsson, 2014, p.9). By implementing the use of critical reflection within social work education and practice, one becomes “capable of working against oppression and injustice” (Brookfield, 2009; Dominelli, 2002; Fook, 2002; Fook & Gardner, 2007; Mattsson, 2010; Morley, 2004; Pitner & Sakamoto, 2005; as cited in Mattsson, 2014). Those in social work education may be able to identify particular biases they may have in their experiences by taking an intersectional approach. The identified steps of implementation (Mattsson, 2014, p. 13) include identifying critical instances and descriptively define its details, reflecting critically on the description to pinpoint power relations, and reconstructing the strategies for the theory that helps an individual identify their agency and power as well as their impact on practice. Inviting the idea of adapting strategies used on a case-by-case basis to increase the quality of support and advocacy offered to clients by professionals, educational teachings and training are enhanced in theoretically grounded substance.

As essential to successful social work practice, cultural competency and critical reflection, prepares future professionals to identify generalizations made about a particular group while recognizing the inability to presume the experience of a member within such groupings (Hancock, 2007; Warner & Brown, 2011; as cited in Robinson et al., 2015 p. 509). "An intersectional approach removes the tendency to aggregate social identities as if there were no dynamic interaction among them and transforms the framework through which clients are viewed into one of complexity and uniqueness" (Hancock, 2007; Warner & Brown, 2011; as cited in Robinson et al., 2015). While it is acknowledged that intersectional frameworks enhance social work education and future practice, it is rarely used within social work classes (Robinson et al., 2015, p. 510). Intersectionality education requires the full understanding of the theory by the educator to properly represent diverse experiences (Jone & Wijeyesignhe, 2011; as cited in Robinson et al., 2015). Using a learning community approach (Alejano-Steele et al., 2011; as cited in Robinson et al., 2015), faculty must engage with diverse groups of educators or disciplines while participating in training that facilitates self-reflection and discussion within a safe environment before introduction within the classroom. This practice allows educators to realize elements that aid in the creation of a safe space in which personal experiences of students may be constructively shared in conjunction with educational material. Should a classroom be void of personal experiences and reflection, intersectional education will not occur; safety and personalization allow intersectionality to be taught through the lens of multi-faceted individuals rather than using the assumptions of experiences by the educator. Additionally, challenging assumptions about identities is an important detail within intersectionality education (Davis, 2010, p. 139; as cited in Robinson et al., 2015). To accomplish such a cohesive and complex learning model, additive of multimedia content, service projects, professional experiences, and other high-impact practices allow students to fully embrace intersectional experiences through self-investigation, first-hand experience, and reflective exploration (Banks, Pliner, & Hopkins, 2013; Case & Lewis, 2012; Ferber & Herrera, 2013; Goodman & Jackson, 2012; Lee, 2012; Kuh 2008; as cited in Robinson et al., 2015, p. 510).

Gaps in Teaching Intersectionality

Despite professional and educational standards inclusion, social work lacks intersectionality teaching. “Although using an intersectional framework in social work education enhance students’ future work with clients, this approach has been rarely incorporated into social work classes” (Robinson et al., 2015, p. 510), producing a limitation in fully understanding the experiences others and one’s personal participation in creating such an experience. A barrier to intersectional inclusion is the lack of research-based teaching methods specifically targeting intersectionality education within social work (Luft and Ward, 2009, as cited in Robinson et al., 2015), and since social work education now mandates intersectionality as essential for assessment and practice, “it is critical for theory and scholarship to support a greater understanding of how interconnected systems of inequality operate on multiple levels and how this affects marginalized people”(Mehrotra, 2010, p. 419). Aiding in perpetuating limiting educational experiences, is the seldom created literacy based in intersectionality for undergraduate social work education. “Much of the academic literature on teaching intersectionality has originated from disciplines outside social work” (Robinson et al., 2015, p. 511), which allows educators and programs to omit intersectional practices and exercises from curriculum easily. By not regularly producing complex networks between intersectional identities in “tandem” with one another within educational settings, “significant gaps emerge in the scholarly literatures on identity” (Nelson et al., 2015, p.

172). With gaps, students are continuously taught using methods that perpetuate confusion in experiences as well as isolation of identities. Confusion occurs due to the perception of binary identities in comparison to lived experiences and personal, identity-based knowledge (Nelson et al., 2015, p. 172). Limiting students to fixed, often generalized labels prevents critical and profound understandings of power structures, social constructs, and interlocking oppressions. Similarly, students typically privileged within their given system miss potentially enlightening opportunities to recognize their participation within inciting oppression, which may negatively impact the collective understanding of one's environment as well as one's relative oppression or privilege compared to others.

Conclusion

This review aimed to identify gaps in literature and teaching as it pertains to intersectionality as a tool in higher education. The research shows that intersectionality is a highly informative and necessary lesson, especially in the social work profession. However, there is a lack of methods for teaching intersectionality in social work higher education (Robinson et al., 2015; Nelson et al., 2015). As previously identified, there is a lack of the literature on a certain subject, significant connections between issues are lost (Nelson et al., 2015). Among the sources, each targeted the idea of intersectionality as an enhancement of understanding and the common ways practice was improved upon through implementation of teaching or utilizing intersectionality. The CSWE (Jani, Pierce, Ortiz, Sowbel, 2011) has identified that diversity has been a transformative substance within social work for decades and aims to continue the revision standards to reflect the current social issues within the overall population. Intersectionality as a teaching tool is capitalized to incorporate the growing awareness of matters relating to interlocking identities that either enhance or diminish the experience of oppression within an individual. Thus, as a means of increasing diversity within the classroom and eventually the field, as well as continuing the educational standard of producing informed, culturally aware, and respectful professionals, intersectionality and the methods by which it can be taught in higher education must be represented.

References

Hulko, W. (2009). The Time-and Context-Contingent Nature of Intersectionality and Interlocking Oppressions. Affilia: Journal of Women & Social Work, 24(1), 44-55. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=36002138&site=ehost-live

Jani, J. S., Pierce, D., Ortiz, L., & Sowbel, L. (2011). Access to Intersectionality, Content to Competency: Deconstructing Social Work Education Diversity STANDARDS. *Journal of Social Work Education*, *47*(2), 283-301. doi: 10.5175/JSWE.2011.200900118. http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=108243450&site=ehost-live

Jones, K. (2013, November 22). Intersectionality and ameliorative analyses of race and gender. Retrieved December 19, 2016, from http://link.springer.com/article/10.1007/s11098-013-0245-0

Mattsson, T. (2014). Intersectionality as a Useful Tool: Anti-Oppressive Social Work and Critical Reflection. Affilia: Journal of Women & Social Work, 29(1), 8-17. doi: 10.1177/0886109913510659. Retrieved from http://search.ebscohost.com.proxy2.library.illinois.edu/login.aspx?direct=true&db=sih&AN=93390171&site=ehost-live

Mehrotra, G. (2010, October 15). Toward a Continuum of Intersectionality Theorizing for Feminist Social Work Scholarship. Retrieved December 19, 2016, from http://journals.sagepub.com/doi/abs/10.1177/0886109910384190

Nelson, J. D., Stahl, G., & Wallace, D. (2015). Race, Class, and Gender in Boys' Education: Repositioning Intersectionality Theory. *Culture, Society and Masculinities, 7*(2), 171-187. doi: http://dx.doi.org.proxy2.library.illinois.edu/10.3149/CSM.0702.171

Robinson, M. A., Cross-Denny, B., Kyeunghae Lee, K., Werkmeister Rozas, L. M., & Yamada, A. (2016, August 31). Journal of Social Work Education. Retrieved December 19, 2016, from http://www.tandfonline.com/doi/citedby/10.1080/10437797.2016.1198297?scroll=top&needAccess=true

The Comorbidity of Diabetes and Depression among Latinas: A Literature Review

Caroline R. Quintanilla, BSW

University of Illinois at Urbana Champaign

Diabetes remains one of the most prevalent and threatening health disparities in the United States today. Increased societal recognition of depression as a crucial facet of mental health/wellness has presupposed escalating diagnosis rates. Diabetes and depression commonly co-occur and go undetected in primary care settings. Women and Latinos/as have higher rates of either diabetes or depression than non-Hispanic Whites. The aim of the study is to determine the role of diabetes and depression among Latinas in the United States and to determine limitations in existing literature. Expanding integrated health care systems with prevention and treatment programs for diabetes and depression is necessary. This is pertinent to Latinas because of specific factors that impact their likelihood of developing these diseases. Frequent depression screenings throughout the lifespan are warranted to monitor rates of depression. More research must be done to assess the severity of the comorbidity. Through reviewing the literature, it was found the relationship between diabetes and depression among Latinas is bidirectional and more research is necessary to better understand this relationship, which is provoked by factors specific to the Latina lifestyle. There is a lack of research conducted on Latinas and few studies focused on this population.

Key words: Diabetes, depression, comorbidity, and Latino/a

Introduction

Background: Why Look at Diabetes and Depression?

Diabetes remains one of the most prevalent health disparities in the United States today (Selvin, 2014). It is estimated nearly 21 million adults in the U.S. acquired diabetes by 2010, which represents approximately 9.3 percent of the U.S. population compared to 5.5 percent two decades ago (Selvin, 2014). The prevalence of diabetes in adults has doubled and is expected to rise significantly (Selvin, 2014). Certain factors, such as lack of education and low socioeconomic status also play roles in the rates of diabetes development (Altun, 2014). Not maintained, diabetes can have serious medical consequences, such as high blood pressure, strokes, and kidney disease (ADA, 2016). Given these consequences, diabetes represents a threat to achieving overall wellbeing.

Health care professionals' increased attention on the rising prevalence of depression has turned it into one of the most widely discussed and most burdensome diseases, according to the World Health Organization (Kessler, 2003). Health care professionals are more open to discussing depression with their patients, which insinuates larger numbers of men and women are seeking medical treatment for the disease (Kessler, 2003). Research has shown depression is a disease that commonly co-occurs with other illnesses—causing comorbidities (Kessler, 2003), approximately 64 percent of a 5,500 respondent subgroup reporting this (Kessler, 2003). With this in mind, depression could be utilized as an indicator disease to determine evidence of other mental/health related disparities, and therefore can be positively utilized.

Latina/os and Mental/Physical Health Disparities

Minority groups tend to experience higher rates of mental and physical health disparities than non-Hispanic Whites (Myers, 2015). This may be because of the unique stressors people of minority status experience such as: discrimination, low socio-economic status, or recent immigration status (Myers, 2015). There are multiple models suggesting psychosocial stressors could play a large role in the onset and development of specific health disparities such as high blood pressure and hypertension (Dressler, 2005). This collection of models emphasizes the role stress plays in the development of depression and anxiety, which in turn has implications regarding higher rates of health disparities (Dressler, 2005).

The imparity in emphasis of depression and depressive symptoms among Latinas/os is rapidly increasing, and thus, mental health care services are continuously needed to monitor this growing problem. It is unclear whether Latinas/os experience depression or depressive symptoms at similar rates to their non-Hispanic White counterparts. Because many more studies are conducted on non-Hispanic Whites, it is important to consider this population as a frame of reference for this diseases' prevalence. While one study found domestic Latina/os, or those currently living in the United States, tend to experience similar rates of mental health disparities as non-Hispanic Whites (Lopez, 2012), another study contradicts this by saying Latinas/os experience a greater number of depressive symptoms than non-Hispanic Whites (Leung, 2014). Although this review was limited by this discrepancy in data, there were sources that elaborated on these points, thus explaining what *is* known about the issue.

Leung (2014) attributes his finding that Latinas/os experience greater numbers of depressive symptoms to problems with acculturation, language barriers, and in some cases intimate partner violence, particularly among Latina women. Both Lopez and Leung's results indicate depression tends to go untreated more among Latinos than non-Hispanic Whites and this is typically a result of not following up with care after diagnosis. This suggests the need for improvement in the areas of screening—particularly with regards to the sensitive cultural needs of Latinas/os—and following-up with practicing clinicians. Following, there are many reasons why Latinas/os are less likely than non-Hispanic Whites to follow up after a depression diagnosis, and it could be partially because of the difference between Latino and Western worldviews. Latinas/os seek support from family members—*familismo*—rather than choosing professional guidance for serious problems, and therefore assume a role of independence in their diagnosis that ultimately leads to a prolonged period of depression. This could also be a result of a lack of formalized health care, or knowledge about options or resources for aid (Leung, 2014). This indicates a need for cultural sensitivity with the needs of Latinas/os in health care settings.

Physical disparities, particularly diabetes, remain prevalent among the Latina/os in the U.S., and they are often better understood than mental health disparities, which make them easier to detect widely across such a large population. Latinas/os are the largest minority group in the United States, accounting for 17 percent of the country's population (Schneiderman, 2014). Diabetes prevalence within subgroups ranges from 10.2-18.3 percent and therefore is alarmingly present among current U.S. Latinas/os. Schneiderman's findings are similar to those of Pineda Olivera (2007), who compared Latinas/os' high rates of diabetes with those of non-Hispanic Whites and found greater rates among Latinas/os. The urgency for detecting comorbid diabetes and depression is escalated by the idea that the longer a person lives with diabetes, the more likely the person is to develop depression (Pineda Olivera, 2007). In light of the rapidly growing minority presence, which is up to 38 percent and projected to comprise 56 percent of the United States population by 2060, the aforementioned findings necessitate an increase in health disparity research—particularly into socioeconomic or other conditions that may predispose Latinas/os to higher comorbidities with mental illnesses (U.S. Census Bureau, 2015).

Women versus Men

Women experience higher rates of depression: a rate almost twice as likely as men (Alegria, 2004 & Kim, 2015). Men and women develop depression at different rates for a variety of reasons. Alegria (2004) found discrimination provided a worthy indicator of major depressive disorder (MDD), and therefore determined focus groups where men encountered the least amount of discrimination consequently faced the least chance of developing MDD. Likewise, women who faced larger amounts of discrimination were at high risk for developing the disorder (Alegria, 2004).

Additionally, diabetes is found more commonly among women than men (Kim, 2015). Kim (2015) found diabetic risk factors (which ranged between 1 and 5 percent greater than men's) were more prevalent in the women's section of the sample than in the men. Women are also at an increased risk of contracting gestational diabetes during pregnancy (Poulakos, 2015). Gestational diabetes is unique to women and often presupposes developing type 2 diabetes due to the similarities in insulin resistance and tendency for women affected. Ultimately about 16 percent of pregnant women are affected by gestational diabetes (Poulakos, 2015). With the unique risk factors women face, more research is warranted to identify the relationship between women and higher rates of diabetes.

Potential Causes of Comorbidity

Diabetes and depression proportionately function with each other. As Latinas/os with diabetes become more depressed, they reportedly maintain less control over the diabetes (Pineda Olivera, 2007 & Fitten, 2007 & Gross, 2004). Metabolic control as exhibited in a diabetes diagnosis, for example, causes emotional strain for the patient and can lead to a greater likelihood of depression. As the individual is forced to put stronger restraints on his or her lifestyle, it is likely the adjustment will be overwhelming and will impact the individual’s mental health. This is particularly true in the case of Latina women because of socioeconomic status, cultural values, and reluctance to follow-up with health care professionals post-diagnosis (Gross, 2004). Other possible explanations for the increased risk in comorbidity include a dysregulation of the immune system, low intake or impaired metabolism of fatty acids, and increased risk of obesity, which all are impacted by a strict diabetic diet as well as the sedentary lifestyle that often accompanies a depression diagnosis (Knol, 2006).

The added risk of gestational diabetes causes specific complications when assessing the comorbidity of diabetes and depression. Women of Latino descent are typically at a two to four percent risk increase of developing gestational diabetes compared to their non-Hispanic White counterparts (Chasen-Taber, 2010). Being that women who develop gestational diabetes during pregnancy are at a higher risk for developing type 2 diabetes later on, this is a necessary factor to consider. Implications of providing stronger preventative care programs aiding potential cases of gestational diabetes prior to pregnancy would limit the risk of acquiring type 2 diabetes in the mother and prevent greater chances of obesity and diabetes development in the children (Chasen-Taber, 2010).

Comorbidity of Diabetes and Depression among Latinas

Using various depression screenings, it can be inferred depression represents a strong risk factor for diabetes. In a sample size of 1,662 participants with gestational diabetes diagnoses, it was found that 9 percent had an Edinburgh Postnatal Depression Scale (EPDS) score of >12 out of a possible 30—with scores >10 typically signaling possible depression—at the antenatal period of the pregnancy (Chasan-Taber, 2010). Based off of this sample, Hispanic women had a greater tendency to experience depressive symptoms than their non-Hispanic counterparts, at 16 percent and 7 percent respectively. Using other depression screening tools, it was concluded rates of depression ranged from around 25 to 50 percent. It was presupposed there is variability in this range due to differing demographic information, which can be reflective of existing depressive symptoms (Chasan-Taber 2010). Another study looked at 92 Hispanic women with type 2 diabetes that were living in Chicago (Munoz, 2014). The study found that 52 percent of these women struggled with mild depressive symptoms—scores above 16—according to the Center for Epidemiologic Studies Depression scale (CES-D), which ranges from 0 to 60 with scores greater than 16 indicating at least mild depression (Radloff, 1977). Thirty-eight percent of this same sample size struggled with severe depressive symptoms—scores above 23. This can point to a correlation between diabetes diagnoses and depressive symptomology (Munoz, 2014). In a recent meta-analysis, it was found the prevalence of depression is nearly doubled when a person has type 2 diabetes versus not. Across nine studies, it was concluded 37 percent of adults with depression or extreme depressive symptoms would acquire type 2 diabetes (Knol, 2006).

Comorbid diabetes and depression is a strong risk for Latinas in the United States. Limited research shows the comorbidity of diabetes and depression is prevalent among Latinas specifically (Kim, 2015 & Gross, 2005 & Mier, 2008). With Latina women being more prone toward developing both diabetes and depression independently, it provides reason to believe the potential to develop both diseases simultaneously is strong. Future research necessitates emphasizing Latinas as a target population because of their likelihood of developing comorbid conditions, particularly depression and other chronic health conditions including, but not limited to: diabetes mellitus, asthma, arthritis, gout, coronary heart disease, and stroke (Kim, 2015).

Awareness of the comorbidities among Latinas allows practitioners to effectively isolate diseases separately and to take necessary precautions in primary care treatment and prevention practices. Gross (2005) emphasizes it is necessary for Latinas to be at the forefront of treatment procedures for both diabetes and depression because of their greater likelihood of developing these diseases. Additionally, Gross (2005) goes on to caution the association between poor glycemic control and depression is significant and preventing development of these conditions would control the potential for future complications, to which Latinas are prone.

Implications for Health Care Social Workers

Eliminating Risk of Comorbid Diabetes and Depression

There are multiple ways to approach prevention and treatment in order to reduce the risk of acquiring comorbid diabetes and depression. One of the most necessary ways to reduce the likelihood is to prevent diabetes and depression onsets separately. By doing so, healthcare practitioners can limit diagnoses of either disease in one individual. Diabetes is brought on by having a strong genetic predisposition to the disease, belonging to certain ethnic minority groups, or leading a sedentary lifestyle among other factors (Preventing Diabetes, 2014). It follows that in order to reduce the risk of acquiring diabetes through controllable factors, patients should maintain a healthy body weight through regular physical activity and healthy eating (Preventing Diabetes, 2014). Through maintaining low stress levels, both diabetes and depression can be prevented. With the strain of a restricted diet for diabetics comes additional stress that the diet should be maintained. Depression can be caught early on by maintaining average to low levels of stress on a regular basis (Depression, 2015). This goes along with seeking help in times of crisis and taking necessary steps to balance healthy self-esteem. However, depression prevention can be difficult to achieve because of the delicate nature of mental disorders (Depression, 2015). Despite this, health care social workers can take an active role in these preventative steps for healthy living.

As Latinas develop depression, it is important for health care social workers and behavioral health specialists to also screen for diabetes, or vice versa. This would potentially conclude screening is one of, if not the most, necessary tools to eliminate the comorbidity or mitigate the symptoms of either disease. In order to reduce comorbid diabetes and depression, it is imperative to treat patients for depression and diabetes conjointly, which indicates screening should be a priority for all healthcare providers. This would determine whether one, both, or neither of these diseases could be treated.

Prevention: Firmer Standards for Diabetes/Depression Screening Among Latinas

Screening for both diabetes and depression is one of the most effective ways to prevent the onset of diabetes and depression among Latina women. Within the realm of preventative care for both diabetes and depression, there are many options for reducing risk of each disease individually, and doing so will hopefully allow practitioners to isolate comorbid conditions and treat each disease separately (Kim, 2015). Frequency of screening for Latinas ultimately begins with regular visits to primary care clinics and regular follow-up after diagnoses (Lopez, 2012). Diabetes and depression screenings should be frequently mandated throughout the lifespan in order to accurately assess the possibility of developing these diseases. This is particularly relevant for women who have had or can be at a risk of developing gestational diabetes or type 2 diabetes later on (Chasen-Taber, 2010). Routine screenings are essential for pregnant women throughout pregnancy and afterwards because of the increased risk of depression in pregnant and postpartum women, and therefore should be addressed with regular check-ins (Chasen-Taber, 2010). It is absolutely necessary for screenings to occur continuously throughout the lifespan in order to catch the diseases in their developing state and potentially prevent other health disparities in the process. By carrying out diabetes and depression screenings, it is possible to prevent the development of comorbid disorders. For example, when depression is diagnosed, then it would be important to offer women preventative services for diabetes. Moreover, a diagnosis of diabetes is also important and if diagnosed, it should be treated immediately in order to avoid the development of depression. Frequent screenings can be made easier to accomplish through the utilization of health care social workers in health care settings.

Integrated Treatment Programs

Isolating the prevalence of comorbid diabetes and depression among Latinas has significant implications regarding planning of treatment programs. The integrated model of care should be embraced more frequently within healthcare. The integrated model embraces the idea of combining mental health, substance abuse, and primary care clinics into one overall service, which promotes a holistic view on healthcare services. The strength in this model lies in the practitioners. Both mental health and primary health practitioners, often including social workers, can communicate to develop a holistic treatment plan that addresses the possibility of various health disparities existing across the care continuum. It is argued this model represents the most effective way to diagnose multiple comorbid disorders (What is Integrated Care, 2003). This model assists healthcare providers in diagnosing depression and diabetes, making it effective in allowing treatment to be done at one centralized location. It would increase attendance to a patient's mental health therapy services and their primary care physician, ultimately making it easier for patients to access care. By providing an outlet for patients to access both mental and physical health services, the likelihood of patients using both increases, thus allowing health care providers to monitor overall wellbeing.

Limitations of the Literature

Despite a surplus of research relevant to diabetes and depression diagnoses among minority groups broadly, there were few studies focusing on the comorbidity of diabetes and depression among Latinas. Much of existing literature points to both male and female sexes rather than separating them out to analyze this problem. This overall limitation also made it difficult to accurately assess the prevalence of both diseases in a single sample size, and consequently intensified the dilemma in claiming a high comorbidity rate of depression and diabetes in Latinas. This requires more research to be done with the population of minority women, and also in bridging the gap between researching physical illnesses such as diabetes, as well as mental illnesses—depression. There were very few studies that chose to look at mental health variables at all, such as depression and depressive symptoms, in combination with physical health disparities like diabetes. It is not common health disparities are combined with mental health disparities in the literature, and with more research that is willing to bridge that gap, a wealth of possibilities are opened. This warrants more studies to be done that incorporate mental health into a general health assessment. With more research, particularly quantitative studies, the task of assessing the number of women with the comorbidity will be streamlined.

Additionally, because of the changing nature of the depression diagnosis while including studies that looked exclusively at depressive symptoms, it is difficult to assess the validity of studies that choose to look at depression. Specifically, it became problematic when discerning whether studies were choosing to look at the definition of depression as categorical vs. spectrum, and many of the depression screening tools reflect that distinction. Although it would be difficult to assume the mental health field would be able to create one comprehensive, but also effective, screening tool, it would be much more likely each study could look at the specific questions within each tool and speak to the individuality of those questions. This could make depression assessment a more effective process than as it currently stands.

Conclusion

Because women of ethnic minorities tend to be at a greater risk of developing diabetes or depression, this warrants studies to be done solely on Latinas within the United States. Continuing, comorbid diabetes and depression is a serious public health concern, particularly among Latina women due to their growing representation in the United States, unique cultural stance, and various lifestyle factors. The added variable of gestational diabetes being a risk factor among women makes comorbid diabetes and depression a significant health concern. The implications to prevent comorbid diabetes and depression suggest preventing individual diseases can limit the potential comorbidity. However, targeting both diseases can eliminate risk through acknowledging that both diseases function closely alongside one another with overlap in their symptomology. Frequent depression and diabetes screenings (as advocated by health care providers and better education to patients about the risks involved in these diseases) throughout the lifespan can catch the onset of these diseases and prevent comorbidity. More research must be done on this population set to determine the degree to which the comorbidity exists. It is also necessary to consider the varying depression screenings when compiling statistics due to the inconsistency in results that having different depression screenings would provide. Additionally, the integrated model of healthcare can serve as a method of targeting both mental health and primary care, in an effort to prevent depression and diabetes together. This provides a more effective way for Latinas to seek healthcare, which has the potential to increase follow-up care appointments, thus increasing overall wellbeing and holistic health.

Acknowledgements

I would like to thank my research mentor, Dr. Karen Tabb Dina, and the TRiO Ronald E. McNair Scholars Program for their support and continuous guidance. Additionally, my thanks goes to Maria Pineros Leano for collaboration on this research topic, as well as the IDEA Research team.

References

Alegria, M., Vila, D., Woo, M., Canino, G., Takeuchi, D., Vera, M., Febo, V., Guarnaccia, P., Aguilar-Gaxiola, S. and Shrout, P. (2004), Cultural relevance and equivalence in the NLAAS instrument: integrating etic and emic in the development of cross-cultural measures for a psychiatric epidemiology and services study of Latinos. Int. J. Methods Psychiatr. Res., 13: 270–288. doi: 10.1002/mpr.181

Altun, I., Demirhan, Y., Erkek, Y., Peker, A., & Cetinarslan, B. (2014). Subjective well-being of persons with type 2 diabetes mellitus. Population Health Management. 17(4). 253-254. Doi: 10.1090/pop.2014.0013.

American Diabetes Association (ADA). (2016). Living with diabetes: Complications. Retrieved May 12, 2016 from http://www.diabetes.org/living-with-diabetes/complications/?referrer=https://www.google.com/

Chasan-Taber, L., Fortner, R., Gollenberg, A., Buonnaccorsi, J., Dole, N., & Markenson, G. (2010). A prospective cohort study of modifiable risk factors for gestational diabetes among Hispanic women: Design and baseline characteristics. *Journal of Women's Health,* 117-124.

Dressler, W., Oths, K., & Gravlee, C. (2005). Race and ethnicity in public health research: Models to explain health disparities. *Annu. Rev. Anthropol. Annual Review of Anthropology,* 231-252.

Fitten, L. J., Ortiz, F., Fairbanks, L. Rosenthal, M. Cole, G. N., Nourhashemi, F., & Sanchez, M.A. (2008). Depression, diabetes and metabolic-nutritional factors in elderly Hispanics. *The Journal of nutrition, health & aging. 12(9).* 634-640.

Gallo, L., Fortmann,. A., McCurley, J., Isasi, C., Penedo, F., Daviglus, M. & Carnethon, M. (2015). Associations of structural and functional social support with diabetes prevalence in U.S. Hispanics/Latinos: Results from the HCHS/SOL Sociocultural Ancillary Study. *Journal of Behavioral Medicine. 38(1).* 160-170. Doi:10.1007/s10865-014-9588-z

Gross, R., Olfson, M., Gameroff, M. J., Carasquillo, O., Shea, S., Feder, A., Lantigua, R., Fuentes, M. and Weissman, M. M. (2005), Depression and glycemic control in Hispanic primary care patients with diabetes. *Journal of General Internal Medicine*, 20: 460–466. doi: 10.1111/j.1525-1497.2005.30003.x

López, S. R., Barrio, C., Kopelowicz, A., & Vega, W. A. (2012). From documenting to eliminating disparities in mental health care for Latinos. *American Psychologist, 67*(7), 511-523. doi:http://dx.doi.org/10.1037/a0029737

Leung, P., LaChapelle, A. R., Scinta, A., & Olivera, N. (2014). Factors contributing to depressive symptoms among Mexican Americans and Latinos. *Social Work, 59(1)*. 42-51.

Menke, A., Rust, K. F., Fradkin, J., Cheng, Y. J., & Cowie, C. C. (2014). Associations between trends in race/ethnicity, aging, and body mass index with diabetes prevalence in the United States: A series of cross-sectional studies. *Annals of Internal Medicine*. 161(5). 328-335. doi:10.7326/M14-0286

Mier, N., Bocanegra-Alonso, A., Zhan, D., Wang, S., Stoltz, S., Acosta-Gonzalez, R., & Zuniga, M. (2008). Clinical depressive symptoms and diabetes in a binational border population. *The Journal of the American Board of Family Medicine,* 223-233.

Myers, H. F., Wyatt, G. E., Ullman, J. B., Loeb, T. B., Chin, D., Prause, N., Liu, H. (2015). Cumulative burden of lifetime adversities: Trauma and mental health in low-SES African Americans and Latino/as. *Psychological Trauma: Theory, Research, Practice, and Policy, 7*(3), 243-251. doi:http://dx.doi.org/10.1037/a0039077

Muñoz, L., Del Carmen, M., Jacobs, E. A., Escamilla, M. A., & Mendenhall, E. (2014). Depression among diabetic women in urban centers in Mexico and the United States of America: a comparative study. *Revista panamericana de salud publica*, *36*(4), 225-231.

Kessler RC, Berglund P, Demler O, et al. (2003). The epidemiology of major depressive disorder: results from the national comorbidity survey replication (NCS-R). *JAMA.* 289(23), 3095-3105. doi:10.1001/jama.289.23.3095**.**

Kim, W., Shin, D., & Song, W. (2015). Depression and its comorbid conditions more serious in women than in men in the United States. *Journal of Women's Health,* 150701135243007-150701135243007.

Knol, M. J., Twisk, J. W., Beekman, A. T., Heine, R. J., Snoek, F. J., & Pouwer, F. (2006). Depression as a risk factor for the onset of type 2 diabetes mellitus: A meta-analysis. *Diabetologia*, 49(5), 837-845.

Pineda Olvera, A. E., Stewart, S. M., Galindo, L., & Stephens, J. (2007). Diabetes, depression, and metabolic control in latinas. *Cultural Diversity and Ethnic Minority Psychology, 13*(3), 225-231. doi:http://dx.doi.org/10.1037/1099-9809.13.3.225

Poulakos, P., Mintziori, G., Tsirou, E., Taousani, E., Savvaki, D., Harizopoulou, V., & Goulis, D. (2015). Comments on gestational diabetes mellitus: From pathophysiology to clinical practice. *Hj Hormones, 14*(3), 335-344.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurements*, 1, 385-401.

Schneiderman, N., Llabre, M., Cowie, C. C., Barnhart, J., Carnethon, M., Gallo, L. C., & Aviles-Santa.M. L. (2014). Prevalence of diabetes among Hispanics/Latinos from diverse backgrounds: The Hispanic community health study/study of Latinos (HCHS/SOL). *Diabetes Care*, 37(8), 2233-2239. Doi:10.2337/dc13-2939

Selvin, E., Parrinello, C.M., Sacks, D.B., & Coresh, J. (2014). Trends in prevalence and control of diabetes in the United States, 1988, 1994 and 1999-2010. *Annals of Internal Medicine, 160*(8), 517-525. doi:10.7326/M13-2411

United States Census Bureau (2015). U.S. Census Bureau report analyzes U.S. Population Projections. Retrieved May 10, 2016, from https://www.census.gov/newsroom/press-releases/2015/cb15-tps16.html

N.A., (2015). Depression (major depressive disorder). Retrieved August 4, 2015, from http://www.mayoclinic.org/diseases-conditions/depression/basics/prevention/con-20032977

N.A., (2014). Preventing Diabetes. *Centers for Disease Control and Prevention*. Retrieved August 4, 2015, from http://www.cdc.gov/diabetes/basics/prevention.html

N.A., (2003). What is integrated care? Retrieved August 4, 2015, from http://www.integration.samhsa.gov/about-us/what-is-integrated-care

Policy Analysis

Illinois Early Intervention Services Systems Act and Potential Return on Investment for Local Agencies and School Districts: A Researched Based Policy Analysis

Lorna Gilmore
University of Illinois at Urbana Champaign

The Illinois Early Intervention Services System Act was created when Illinois lawmakers noticed there was a need for children ages 0-36 months with developmental delays to access educational intervention services. As of 2007, nearly 17,000 children ages 0-36 months were receiving services from this policy. This number is nearly 4 percent of the entire Illinois population of 0-36 month old children. Children in rural Illinois communities have an especially hard time receiving proper services. Poverty stricken families also have difficulty finding adequate child care, thus leaving them with virtually no choice but to care for their children with developmental disabilities on their own. Since the implementation of this policy, it has been found to be extremely successful in helping children and their families cope with developmental delays. The cost of running these programs far under weigh the costs of caring for a child with developmental delays once they reach elementary school and later childhood. If more community agencies and school districts would provide services like these, the return on investment would be significantly higher considering these programs tend to cost less than the services children receive in later childhood. It is up to the state of Illinois to provide more funding for these programs. Once this happens, it is up to local agencies to seek these State funds and to create more resources for children 0-36 months in their community.

Key Words: Early Intervention Services, Individualized Family Service Plan, Return on Investment, Developmental Delay, At-Risk Child

Illinois Early Intervention Services Systems Act

In the late 1980's, the issue of children with developmental delays in Illinois not receiving proper services came to the forefront. In 1988, the Illinois Early Intervention Services Systems Act was introduced into legislation. This policy was created in response to the issue of Illinois' children 0-36 months not being eligible for early intervention educational services. Children lacking these services therefore were faced with delays that created more issues later in childhood and forced them to be held back when they did reach pre-kindergarten and kindergarten (Fowler, 2016, pg. 5). The law states the State of Illinois must provide these children with early intervention services at the youngest stage of life in order to verify the future of these children and the future of our society.

Historical Background of the Policy

The lack of educational resources for children with developmental delays 0-36 months old has long been an issue in the history of American's education system. These children lack the developmental skills to qualify for special education services in pre-kindergarten programs. Developmental delays are defined as a condition where a significant delay is cited within the process of development for children ages 0-8 years (Department of Education and Early Childhood Development, 2001). In addition to the educational setbacks, children with developmental delays could acquire secondary impairments and disabilities caused by poor health and lack of parental knowledge about the disability the child faces and how to properly care for it (ILCS 325, 2001).

Several changes have affected the policy since it was originally signed in 1992, with most changes taking place nearly a decade later in 2001. The most significant of these changes being 'private insurance exemption' meaning children covered by private insurance have access to services even if their service provider denies these services (ILCS 325, 2001). In 2013, more changes affected the bill when the Individuals with Disabilities Act (IDEA) was revamped by the Federal Government. After 2013, all parts of Early Intervention Act have to comply with the legislation put into place in the Individuals with Disabilities Education Act. However, there are still additional problems that affect the implementation of the Early Intervention Act.

Description of the Problem that Necessitated the Policy

Early Intervention Systems Services are built around the fact that infants and toddlers, 0-36 months, may not have received appropriate therapeutic services. Lack of care in these young children can increase the pervasiveness of developmental delays already present in these children. This lack of care can also impede development later in childhood and into the child's adult life. As of 2007, Illinois was ranked 13th out of 50 states in providing most children under the age of three with services. In 2007, 17,489 children in Illinois had active Individual Family Service Plans (Dep. Human Services, 2007). That is equal to 3.11 percent of the population in this age group. The intersection of these two converging identities, that of being low income as well as having children with special needs, creates a large part of why the services are not available to most families in our State (ILCS 325, 1988).

Many groups are affected by this policy and are invested in it. The largest group of people invested in the need for these services is the children who are affected by developmental delays. The families of these children also are affected by the need for these services, which provide several assistance programs such as free educational child care and programing opportunities so parents are better able to care for their children with special needs (Dep. Human Services, 2007). Teachers in the school system are also largely affected by these early intervention services. School systems were finding students were entering kindergarten unprepared for the curriculum, thus forcing the teachers to hold them back in school. The communities where these special needs children reside should also be invested in this legislation because the improvement of services for one population of their community can greatly affect their entire community due to the trickle down benefits.

Policy Description

Families in the state of Illinois who have one or more of previously mentioned intersecting identities and issues such as intersection socioeconomic status, race, and geographical location are referred to an agency for evaluation. This policy must follow a strict protocol when being implemented into services. First the child is referred to a screening process. Specialists licensed by the State board are in charge of facilitating these screenings. If the child is found to be at least 30 percent or more below the average development of a same-aged child they are eligible to receive services (ILCS 325, 1988). If the child is accepted into an agency, the agency will first create an Individualized Family Service Plan for the child's family. Essentially, this is a course of action and rehabilitation the family and agency personnel will take while caring for the child. The child is eligible to receive therapeutic services until his or her third birthday, or until he or she is no longer 30 percent or more below developmental expectations (ILCS 325, 1988).

This policy is expected to provide several resources and opportunities to the families and children affected by developmental delays. This policy affirms the importance of a child's family in deciding what elements go in to his or her learning plan, and it takes in to consideration the child's developmental level. This policy is also intended to provide more of an individualistic approach to the care for children with developmental delays. The policy also looks at how the community as a whole can benefit from these services by providing several forms of early intervention services such as speech therapy and physical therapy.

The primary target population covered under this policy are 0-36-month-old children with developmental delays, physical or mental disability, or children ‘at risk’ of having developmental delays. Children who are taught a first language other than English can often times be covered under these services as well. Children with other language, hearing, and speech barriers can also receive services from these programs (Dep. Human Services, 2007).

The most crucial part of this policy’s implementation is the establishment of the “Illinois Interagency Council on Early Intervention. This council is composed of 20 to 30 individuals (ILCS 325, 1988). The governor is responsible for appointing council members. The lead agency heading the policy is the Department of Human Services; however, the council approves the budget as well as implements all program decisions.

This policy has several different short and long-term goals for both the individual agencies as well as for the State as a whole. Some goals for the individual agencies include coordinating public awareness in the community as well as coordinating local planning and evaluation of children who could possibly benefit from their services. The local agencies are also responsible for reporting to the State council, looking at local needs, and determining how to properly take care of these needs (ILCS 325, 1988).

On the State level, the policy goals are a little different. The State focuses on creating informational documents such as timetables showing when appropriate early intervention should occur and what the curriculum in these interventions should look like.

Both the State and local levels work to make the public aware of possible warning signs of developmental delays (Dep. Human Services, 2007).

This policy is funded through State and Federal funding. If the public or private service agencies are approved by the State licensing council, then they are eligible to receive these State and Federal funds. The Illinois General Assembly puts aside a certain amount of the Department of Human Services budget to go toward these early intervention services. Federal funds allocated to Early Intervention Services are provided under the "Disabilities Education Act". Some private providers receive funds from a family's private insurance plans if they choose not to opt out. There is also a small fee for each family based on the families' income, these fees can be as small as $10 a month (Dep. Human Services, 2015).

Each year the Illinois Early Intervention Services Council prepares and submits an annual report to the Illinois General Assembly, as well as to the Governor. This report includes several things such as the number of children who could be receiving services in the state of Illinois and the estimated cost of providing services to these children. The Illinois Early Intervention Services Systems Act is a policy that will be in effect for several years to come. The State board has created scientifically proven timetables that access appropriate interventions and say what age is appropriate for these interventions (ILCS 325, 2001). This model of Early Intervention Services also has been proven to be effective in other states.

Policy Analysis

The goals in this policy that have already been implemented are legal. This policy has been in place since 1992 and because of this, it is easy to analyze the productiveness of the goals within the policy. The Early Intervention Services Systems Act gives children, 0-36 months, who show need of individualized learning this opportunity, thus making the goals of this policy just and democratic. This policy contributes to greater social equality on a micro level, meaning the policy has a large effect on the individual receiving these services, the families of these children, and the communities in which these children live (Dep. Human Services, 2015).

When thinking of social equality rights, people in our society with developmental disabilities are often over looked or pushed to the side. This policy helps to redistribute the resources and rights to these children who are facing inequalities through every aspect of life. Also, by creating programs where families have the ability to access new skills and opportunities to foster a more general and productive knowledge of how to care for their children, our society is helping to reallocate resources to families in need.

The quality of life for these children is affected greatly by this policy. Research has shown the development occurring in toddlers and infants is some of the most important development in a human’s life (Dep. Human Services, 2015). By providing resources in the prime of their development, the policy is bettering the quality of life for these children for years to come. Additionally, this policy cannot cause any harm. It is not necessarily proven to show great success in every child with developmental delays, but it is shown to not cause any extenuating issues in these children’s lives. The goals of this policy are in place to help these children thrive in school and in life, as well as to assist their families (ILCS 325, 2001).

Giving communities information about developmental delays and the children who live with them can help to better the public as a whole, because the community is then more aware and equipped to handle situations where they may interact with these children. This bill was created after the people of Illinois saw a need for services. Children at this young of an age are unable to advocate for themselves so it is important for people like social workers see the need for these services and find a way to provide these services to their clients. Because of this aspect of the Early Intervention policy, several of the goals are consistent with the core values of the social work profession.

The Illinois Early Intervention Services System act is absolutely pertinent to our society. Children with developmental delays can benefit immensely from these services, and it is our duty as caring community members to make sure that eligible children have access to these services. The services provided by public and private local agencies can help the development of a child for several years to come. The future of Illinois children with developmental delays lies in the early intervention programs like the one this policy has created. If every eligible child can receive these services, then our education system, our communities, individual families, and their children will have a much brighter future.

References

Department of Education and Early Childhood Development (n.d.) Retrieved April 27, 2016- http://www.ed.gov.nl.ca/edu/k12/studentsupportservices/developmental.html

Early Intervention Services Systems Act, 1992. *325 Illinois Complied Statues 20/.* Retrieved November 16, 2015.

For Early Intervention Providers. (n.d.). Retrieved November 18, 2015, from http://www.dhs.state.il.us/page.aspx?item=31183

Fowler, S. A. (2016, July). The Early Intervention Program. Retrieved April 27, 2017, from http://eiclearinghouse.org/resources/public-awareness/the-guide/ .