RACE in AMERICA

Restructuring Inequality

FAMILIES, YOUTH, AND THE ELDERLY

The Seventh of Seven Reports on the Race in America Conference

June 3–6, 2010

CENTER ON RACE AND SOCIAL PROBLEMS
SCHOOL OF SOCIAL WORK
UNIVERSITY OF PITTSBURGH

Editors: Larry E. Davis and Ralph Bangs

RACE IN AMERICA: RESTRUCTURING INEQUALITY

FAMILIES, YOUTH, AND THE ELDERLY REPORT

CENTER ON RACE AND SOCIAL PROBLEMS
SCHOOL OF SOCIAL WORK
UNIVERSITY OF PITTSBURGH

Despite significant progress in America's stride toward racial equality, there remains much to be done. Some problems are worse today than they were during the turbulent times of the 1960s. Indeed, racial disparities across a number of areas are blatant—family formation, employment levels, community violence, incarceration rates, educational attainment, and health and mental health outcomes.

As part of an attempt to redress these race-related problems, the University of Pittsburgh School of Social Work and Center on Race and Social Problems organized the conference Race in America: Restructuring Inequality, which was held at the University of Pittsburgh June 3–6, 2010. The goal of the conference was to promote greater racial equality for all Americans. As our entire society has struggled to recover from a major economic crisis, we believed it was an ideal time to restructure existing systems rather than merely rebuilding them as they once were. Our present crisis afforded us the opportunity to start anew to produce a society that promotes greater equality of life outcomes for all of its citizens.

The conference had two parts: 20 daytime sessions for registered attendees and three free public evening events. The daytime conference sessions had seven foci: economics, education, criminal justice, race relations, health, mental health, and families/youth/elderly. Each session consisted of a 45-minute presentation by two national experts followed by one hour of questions and comments by the audience. The evening events consisted of an opening lecture by Julian Bond, a lecture on economics by Julianne Malveaux, and a panel discussion on postracial America hosted by Alex Castellanos of CNN.

This report summarizes information provided by those speakers who focused on race and families, youth, and the elderly. The value of this report is that it provides access to the extensive and detailed information disseminated at the conference. This information will be particularly helpful to community and policy leaders interested in gaining a better understanding of racial disparities in family, youth, and elderly conditions and finding effective strategies for improving these conditions.

Disclaimer:

This postconference Race in America report includes detailed summaries of the presentations and subsequent discussions that took place. Any opinions, findings, conclusions, or recommendations expressed in this report do not necessarily reflect the views of the University of Pittsburgh School of Social Work or Center on Race and Social Problems.

Table of Contents

Strengthening Minority Families

Presenter: Ruth G. McRoy, Donohue and DiFelice Endowed Professor, Boston College
                Graduate School of Social Work

Moderator: Barbara S. Burstin, Holocaust and Jewish Studies Scholar, Department of History,
                University of Pittsburgh

Families in communities of color frequently face several barriers to stability. A person's family life is a great predictor of the achievements or shortcomings that an individual may face as he or she transitions from childhood to adulthood. A quality family structure is made up of several elements, which include love, sufficient income, a job, education, safe environments, parenting skills, a good neighborhood, physical and mental health, and nutritional food. Racial and ethnic minorities often face multiple detrimental factors that threaten stability in their lives and within their families. Some of these factors are lower rates of marriage, higher rates of unemployment, and higher rates of incarceration than Whites. Because of this, people of color—and particularly African Americans—tend to experience higher rates of children born out of wedlock and children entering the foster care system. In order to strengthen families of racial and ethnic minorities, we need to find ways to address poverty, inadequate housing, and parental substance abuse. Also, there need to be more innovative educational programs, like the Knowledge Is Power Program and Urban Prep Academies.

The Problem

Low Marriage Rates

There are many issues that disproportionately affect families of color in the United States. One of these issues is the difficulty people of color have finding a suitable mate. There are only 70 single Black men for every 100 single Black women. Only 45 percent of African American families include married couples, compared to 80 percent for Whites, 82 percent for Asians, and 65 percent for Latinos.

Single-parent Households

As a result of the low marriage rates, African American children are more likely than other children to live in single parent households. For example, 35 percent of Black children ages 0–2 years live in single-parent households compared to 6 percent of White children and 1 percent of Asian children in that same age group. In addition, almost half—42 percent—of all African American teenage children live in single-parent households compared to only 17 percent of White and 9 percent of Asian teens. As these data suggest, the likelihood of living in a single-parent home increases as Black children get older.

Working Parents with Children

In past generations, when a family had children under the age of 18, the mother usually took care of the home while the father worked to earn wages. In 2007, there were 83 million family groups

in the United States; 73 percent were couples and 44 percent had children under the age of 18. Of the families that had children under age 18, 66 percent had both spouses in the workforce.

Causes

The factors impacting African American families historically have been:

- slavery,
- northern migration (loss of communal institutions),
- welfare policies,
- declining job opportunities for Black males,
- isolation in neighborhoods, and
- concentrated poverty.

Living in areas of concentrated poverty has many negative effects for Black families. These families lack safety and have poor physical and mental health, a sense of hopelessness, low education, and diminished life opportunities.

Increase in Children Born Out of Wedlock

In the 1950s, only one in 20 children was born to an unwed mother. Today, the number of children born out of wedlock has increased to one in three. Having a child out of wedlock is three times as common for the poor than for the affluent. Half of the women who give birth out of wedlock have no high school diploma, and nearly a third have not worked in the last year.

Divorce

One of the reasons for the high number of single-parent households is divorce. Thirty percent of children born to married couples will see their parents divorce before they reach age 18. African American divorce rates are higher than that of Whites and Hispanics.

Incarceration

In 2007, 1.7 million minor children had a parent in prison. Imprisoned parents are mostly fathers. Lack of parent-child contact during incarceration jeopardizes the chances of family reunification.

Dropping Out of High School

In 2007, 21 percent of Blacks, 27 percent of Latinos, and 12 percent of Whites dropped out of school. Youths who drop out of school often find it harder to get good jobs as adults and, as a result, face great difficulty taking care of themselves or a family.

Unemployment

The overall unemployment rate in the United States is 9.75 percent. However, once the number of unemployed is disaggregated by race, there is disproportionality along racial lines:

- 8.8 percent of Whites
- 16.5 percent of African Americans (19 percent of males; 12.4 percent of females)
- 12.6 percent of Latinos
- 8.2 percent of African Americans with college degrees
- 4.5 percent of Whites with college degrees

Joblessness is another way to look at unemployment. In 2004, 72 percent of Black high school dropouts in their 20s were jobless compared to 34 percent of Whites and 19 percent of Hispanics.

Digital Divide

There also is a great digital divide growing among low-income families of color. Poorer parents often lack the ability to communicate with educators using methods of current technology, like e-mail, which is becoming a common tool in most schools.

Children in Foster Care

There were 463,000 kids in foster care in 2008 and 123,000 children awaiting adoption. The average length of time that children remain in foster care is 27.2 months. Also, the average age of a child in foster care is 9.7 years. Of the total number of children in foster care, 60 percent are racial and ethnic minorities. African American children are particularly overrepresented in foster care. While they are 15 percent of the U.S. child population, they constitute 31 percent of those in foster care and 25 percent of the children awaiting adoption.

Although the number of children in foster care has decreased in recent years, the number of children who have aged out of the system without finding a permanent home has increased. In the 10 years from 1999 through 2008, 230,000 teens aged out of foster care. The number aging out each year increased from 19,000 in 1999 to almost 30,000 in 2008. These children are less likely to have a high school diploma and more likely to experience economic hardship. They also are likely to have had a child out of wedlock, more likely not to earn a living wage, more likely to become homeless, and more likely to become part of the criminal justice system.

Solutions

We need to ask ourselves the following:

- What can be done?
- What can schools do?
- What can churches do?
- What can agencies do?
- What can we be doing?
- How can we promote happy families that yield happy, permanent homes for children?

For children in foster care, we need to find ways to address poverty, inadequate housing, and parental substance abuse. These are the things that lead to child neglect, family disruptions, and

kids' being removed from birth families. We need to find permanence for children in foster care through a biological connection with extended family, if necessary, or through adoption. We need to create new ways to alert people within the community about children in foster care who need permanent homes. This communication can include outreach to churches, community groups, or any place where large numbers of people gather. It also can include ad campaigns like AdoptUSKids, whose mission is to raise public awareness about the need for foster and adoptive families for children and to assist U.S. states, territories and tribes to recruit and retain foster and adoptive families and connect them with children.

We also need to work on preventing abuse and neglect and on family reunification. We need to find alternative responses to child removal, including early intervention and support programs for parents and kids.

We need to establish innovative educational programs, like:

- The Knowledge Is Power Program (KIPP): A national network of free, open-enrollment college preparatory public schools with a track record of preparing students in underserved communities for success in college and in life
- Urban Prep Academies: A network of free public, comprehensive, high-quality college preparatory education programs open to young men that result in graduates succeeding in college

Further, we need to teach about relationships and parenting in schools.

To increase employment and reduce poverty, we need to:

- establish economic policies that create jobs that support families,
- increase social interventions that teach vital skills related to employment in the community and through community-based programs serving families, and
- create self-help efforts that inspire those who have made it out of impoverished communities to give back.

Domestic Violence and African Americans: Exploring the Intersections of Race and Social Context

Presenter: Oliver J. Williams, Executive Director, Institute on Domestic Violence in the African American Community, and Professor, University of Minnesota School of Social Work

Moderator: Barbara S. Burstin, Holocaust and Jewish Studies Scholar, Department of History, University of Pittsburgh

African Americans and American Indians have the highest levels of domestic violence in the United States. When the social context of abuse is taken into account, domestic violence is higher among African Americans who are in high-stress, low-income environments than among those in middle- and upper-class households. African American rates of domestic violence within middle- and upper-class households are still higher when compared to other races at the same income levels.

A majority of intimate partner violence in the United States is abuse by men against women. It tends to have a high correlation with factors such as unemployment/underemployment, lack of social support, substance abuse, and child abuse or neglect. There are usually multiple social problems facing families that have issues of domestic violence. In order to decrease the prevalence of intimate partner violence in people of color, there needs to be holistic and culturally competent interventions that identify and promote the true desired outcomes of the individuals and the communities they serve.

The Problem

There are several challenges associated with violence in some homes and communities:

- How can we effectively address issues that encourage healing on the part of those who have been victims of domestic violence?
- How do we end up encouraging transformation for those men who can change?
- How can we have conversations about things in authentic ways that really connect with the experience and realities of families?
- How can we prepare children to deal with conflict without it resulting in violence?
- How do you find ways to deal with issues of violence within communities and families?
- How can we find ways to holistically address the multiple issues facing families that experience intimate partner violence?

Causes

Risk Factors for Domestic Violence

Socioeconomic Status: Intimate partner violence tends to be related to lower socioeconomic status. This violence occurs more frequently among couples in low-income households and when

the male partner is unemployed, not seeking work, or underemployed. Although it is true that lower socioeconomic status does not cause domestic violence, it does exacerbate the problem. In addition, domestic violence occurs at higher rates when couples live in poorer neighborhoods, even if both parties are working. African Americans are poor at disproportionately high rates compared to Whites. Even when income and environments are controlled for, racial differences in domestic violence still exist.

Lack of Resources/Social Support: Seventy to 80 percent of abused Black women have left or attempted to leave these relationships. Half of domestic violence homicides were cases where women were killed in the process of leaving the relationship. Many women who leave abusive relationships return to them due an inability to support themselves or to find stable housing. They also may return out of concern for their children and how leaving or the lack of resources that may be associated with leaving could affect them. Among African American women who killed their partners, 80 percent experienced domestic violence.

Women do better when they have support systems and family support. In many cases, the abuser tries to keep the victim away from those who may offer support.

Problems with Substance Abuse: Alcohol problems are more frequently related to intimate partner violence for African Americans than for Whites and Hispanics. In many cases, people who engage in domestic violence while intoxicated continue to abuse their mate even during periods of sobriety or treatment for substance abuse.

Jealousy: African American men, like other men who batter, demonstrate higher rates of jealousy than men who do not batter.

Child Abuse/Neglect: There is a high rate of domestic violence and co-occurrence with other issues, particularly child abuse and neglect. In households where intimate partner violence occurs, children are nine times more likely to come to the attention of child welfare workers.

Reasons that have been identified to explain the prevalence of domestic violence in Black communities include:

- realization of the barriers to being able to achieve manhood in different ways,
- displaced anger,
- poor definitions of respect,
- issues of fatherhood and/or mentoring, and
- poor problem-solving skills.

Solutions

We need to understand the multiple issues that affect families that experience domestic violence. Domestic violence programs that are ineffective tend to have a one–size-fits-all approach when it comes to working with victims and families. Initiatives and interventions have to adjust to the unique social context of domestic violence within the communities they serve.

Real conversation within African American communities needs to be conducted to discern the challenges that batterers and their victims face and the true desired outcomes that people want from domestic violence programs and interventions. In some instances, the violence that may be associated with gang life may be seen as normal behavior to those associated with that culture. Also, a victim of domestic violence may view the act of jealousy on the part of her mate as an outward showing of affection. Effective measures to eradicate domestic violence cannot happen until interventions begin to address issues in relation to the social context of the environments they are serving. In addition, we need:

- more assessment points around challenges that people are facing in communities on a day-to-day basis,
- coordinated community responses in which different community partners come together to give attention to issues of domestic violence, and
- more assistance provided to African American community leaders and providers to help them understand and address the multiple issues fragile families and communities face.

There also are themes to consider as we address domestic violence:

- African American women who stay in abusive relationships
- African American fathering after violence
- Coparenting after violence
- Prison reentry and domestic violence
- Manhood and mentoring young African American men
- Intersection of substance abuse and domestic violence
- Sexism

Suggested Readings

Edleson, J., and Williams, O.J. (2006). *Parenting by Men Who Batter: New Directions for Assessment and Intervention*. Oxford University Press, USA.

Rich, J.A. and Stone, D.A. (1994). The experience of violent injury for young African-American men: The meaning of being a "sucker." *Journal of General Internal Medicine*, 11(2): 77–82.

Richie, B.E. (1995). *Compelled to Crime: The Gender Entrapment of Battered, Black Women*. New York, N.Y.: Routledge.

Race and Ethnic Group Disparities over the Life Course

Presenter: James S. Jackson, Daniel Katz Distinguished University Professor of Psychology, University of Michigan

Moderator: Richard Schulz, Professor of Psychiatry; Director, University Center for Social and Urban Research; Director of Gerontology; and Associate Director, Institute on Aging, University of Pittsburgh

Discrimination, such as biases, prejudice, and stereotyping, create much of the disparity in health and health care that exists throughout the life course for people of color today. Power, social participation, social environment, behavior, and early life all have significant influence and effect on social inequalities and health throughout the life course of racial and ethnic minorities in the United States. Currently, an eight-year gap exists in life expectancy at birth between Whites and Blacks. It would take an estimated 60 years at the current rates for Blacks to achieve equality with Whites in life expectancy. In addition, the United States is becoming more unequal in the distribution of economic resources, more racially and ethnically diverse, more materially disadvantaged, and more geographically segregated. There are those who would like to associate the health disparities that African Americans face with genetics. However, there is little to no evidence that can link the genes that account for skin tone and other physical characteristics that we use to define race with any of the complex assortments of genes that are associated with illnesses such as diabetes or hypertension. The determinants of poor health have more to do with behaviors in which people engage, the environments in which people live, and the social stressors that people encounter in their daily lives. These factors often are much more problematic in the lives of racial and ethnic minorities, thereby making them more susceptible to illness. Social and political changes are needed if we are to adopt effective strategies for improving health and health care for this and the next generation of racial and ethnic minorities. This will benefit not only African Americans but also the growing ethnic and racial populations in this country and, in fact, our society as a whole.

The Problem

The aging society is driven by a drop in fertility and by people living longer. In the near future, there will be more people over 60 than there are under the age of 15. In years to come, younger generations with become much more racially heterogeneous than older generations due to higher fertility and increased immigration of racial and ethnic groups.

Life Expectancy and Race

There are large differences in life expectancy at birth between Whites and Blacks. The life expectancy for Whites in the year 2000 was 77.4 years, compared to 71.7 for Blacks. At the current rates, parity of life expectancy between Whites and Blacks will not be reached until the year 2071. Also, pregnancy mortality rates for Black women worsen as their levels of educational attainment increase. In addition, the probability of survival from age 15 to 65 years is almost 10 percent higher for poor Whites than it is for nonpoor Blacks.

Genetically Defined Groups

Attempts to order human variability into discrete genetically defined groups racializes health disparities and reifies human group differences. It encourages uncritical acceptance of some disparities and pathologizes certain groups. It also distracts attention from exploring how social life is expressed biologically. Ultimately, any effort to categorize human variability in this fashion will inhibit the ability to act on political, economic, and social factors that are known to produce poor health.

Causes

The life course is very important in terms of understanding human development. It is a major factor in how we understand race in the United States. Race influences the experiences of individuals throughout the duration of their lives. Social, economic, and political context: history: life course: and their intersections are clearly at the epicenter of understanding human development. These factors may be even more important in understanding the developmental trajectories of discriminated against ethnic and racial groups over the life course.

Four Eras of Racial Subjugation in the United States

Slavery: During this period, total control over people from Africa was exercised by private industry and abetted by the government for purposes of economic growth and development of the country. During this period, theories of racial classification were developed to justify and rationalize the subjugation of an entire class of people in a general worldwide trend of enlightenment and democratic ideals.

De Jure Segregation: During this period after slavery, Blacks continued to be discriminated against based upon a set of legal tenants and national and state laws that were developed to maintain the relative social and economic position between Blacks and all other peoples in the immigrant United States. This is the beginning of the "at least you are not Black" era.

De Facto Segregation: This was a major period of continued maintenance of relative differences between Blacks and others enforced by social convention and, when necessary, vigilantism and violence, especially in the South. It also was maintained in the North through a series of often unwritten but powerful beliefs and behaviors, including geographical redlining, mortgage preferences, housing codicils, social and economic segregation, and others.

Status Quo Subjugation: This is the period we are in today—a period in which many can point to the legislation of the late 1960s as markers of Black Emancipation and as a signal that equality exists among the "races." In this period, many people are concerned about the ways in which the government oppresses Blacks by forcing them to wear the label of Black and the need to free people to be whatever they want to be. This is a period of "don't know, don't tell." The Civil Rights Acts do guarantee citizenship for African Americans, but they do nothing in the way of guaranteeing economic justice. As a result, this legislation has created the "disappointed generation" among African Americans who saw very few of the expectations for a better life come to fruition.

Why Life Course Disparities Persist in Today's Society

- Reductionist thinking—cognitive distortion that fails to recognize the interconnectedness of factors or causes
- Disparities provide an effective rationale for continued subjugation
- Powerful and parsimonious explanation for why my group is good and your group is bad
- Disparities contribute to continued rationale for "racial" segregation, especially restrictions on group intermarriage

Markers of Race

- Race may offer some basis for genetic groupings, but it is hardly definitive for observed health differences.
- Race as merely a social construction is probably too simplistic.
- Race is most likely a social construction based upon genetically caused phenotypical differences—observable traits or characteristics.
  - We categorize people based on genetic markers such as skin color. These categorizations are unimportant with regard to how Americans understand race.
- The genes responsible for observable racial markers are the most unstable and under the most selective pressures.
  - These genes are the most unstable and the least important with regard to what is known about the human genome.
  - There is no evidence that links the genes that create skin color or other visible racial characteristics to the complex genes that are related to health issues like diabetes and obesity.
- In parsing out causal factors, environmental and gene/environmental interactions are probably most important in any health and disease risk assessment.

Alternative Theories about the Major Marker of Race

Skin tone is the most often used marker of a person's race. However, skin tone is most likely related to selection pressures (vitamin D and reproduction) and is thus unstable. Dark skin evolved to protect against breakdown in folate, a nutrient essential for fertility and for fetal development. Skin that is too dark blocks sunlight needed for vitamin D production, which is critical in maternal and fetal bones. Thus, humans have evolved to be light enough to make sufficient vitamin D yet dark enough to protect stores of folate. However, when we construe race (ethnicity, etc.), there are two operative processes in group categorization:

- Biological—phenotypical differences and
- Social—self and other meanings

It is far-fetched to think that biological process alone could account for observed group differences in health in the United States. Social processes must play a major role.

Historically, African Americans and Caucasians are the only racial groups that do not dispute their racial characterization of being labeled as Blacks or Whites, respectively. Other groups, such as Asians, Hispanics, and Afro-Caribbeans, tend to dispute being labeled solely as Black.

Race and Chronic Stress

The chronic stress process is one possible pathway for physical and mental health disparities among racial and ethnic minorities. Three of the major culprits for producing stressful effects are the following:

- Discrimination and perceived racism—a class of stressors that have been shown to have health and mental health effects among racial and ethnic minorities
- Discrimination operating in the context of social, political, economic, and cultural influences over the individual and group life course
- Discrimination and perceived racism as well as other non-race-related stressors tied to poor structural life conditions, which probably play a role in health and mental health processes, but the role is complex.

The "law of small effects" in race-related outcomes states that there is no one single factor that produces observed physical health disparities among racial/ethnic groups in America. Instead, it is a group of small differences, which may accumulate over the life course to produce observed differences in adulthood and older ages among different race/ethnic groups. Those factors may include:

- gene/gene and gene/environment interactions,
- discrimination and perceived racism (stress process),
- cultural factors,
- behavioral differences,
- SES and institutional arrangement, and
- social and psychological factors.

Disparities in Demographic, Economic, and Social Resources: Structural Inequalities

The United States is becoming more unequal in the distribution of economic resources and more racially and ethnically diverse. Blacks remain materially disadvantaged and geographically segregated.

There also are large disparities, such as neighborhood segregation and differentially stressful communities, that exist in living arrangements favoring non-Hispanic Whites. These neighborhoods afford differential opportunities like access to food, services, and jobs and afford differential coping resources, such as fast food outlets, liquor stores, and illegal drug distributors.

Disparities in Health Status, Health Services, and Mental Health: Physical and Psychological Inequalities

Large disparities in rates for all causes of death exist among ethnic and racial groups, and these differences are not due in any simple way to socioeconomic status. Infant mortality rates have declined but large differences exist between African Americans and Whites. There also are large disparities in health care use between African Americans and Whites.

Health Disparities by Age, Aging and the Life Course

Disparities in health tend to increase as people of color get older. There are links from childhood (infancy, neonatal care, pregnancy, etc.) social conditions to racial/ethnic disparities in adulthood and older age. Over the life course, Blacks more than any other group live the fewest years, and a high proportion of these years are lived in poor health. Health, race, ethnicity, and mobility are linked in complex ways across childhood, adolescence, adulthood, and old age. As people of color increase in age, they are more susceptible to endocrine, nutritional, and metabolic diseases because the stressors they endure over their life course begin to have a greater impact.

Health Behaviors Parallel Racial and Ethnic Disparities

Poor health behaviors, such as smoking, heavy alcohol use, drug use, and obesity, increase in African American males and females as they get older. Also, vigorous physical activity sharply decreases in Blacks as they grow older.

Mental Health Disparities

In comparison to health statuses, mortality, and poor health behaviors, prevalence rates for major psychiatric disorders reveal few, if any, Black/White disparities favoring Whites.

Solutions

We need to focus more on the heterogeneity produced by race, ethnicity, class, gender, immigration, and other conditioners of life, including the life course. Explicit or implicit assumptions of homogeneity in research on and policy formulation regarding ethnic and racial populations are no longer tenable.

We must develop effective strategies for this society to make social and political changes for this, and the next, generation of Black Americans who, after all, constitute one of our oldest groups of American citizens. This strategy not only will benefit Black Americans but also will be of benefit to the growing ethnic and racial populations in this country and, in fact, our society as a whole.

We also need to encourage the development of relevant ongoing demographic, economic, social, and policy relevant studies, like the National Survey of American Life[1], that address the nature of the African American population in this more ethnically and racially diversified nation of the 21st century.

The specific policy implications are as follows:

- Create a sustained, broad-based focus by government and private organizations on providing a wide range of social and economic opportunities.
- Develop policies to improve family support systems, finance education reform, and provide opportunities for intergenerational wealth accumulation.
- Find common objectives among racial and ethnic minority groups as a basis for building effective coalitions within and across age cohorts.
- Eliminate ongoing racial and ethnic discrimination through more vigorous monitoring and enforcement of antidiscrimination laws (already on the books) in housing, politics, employment, education and schooling, and the criminal justice system.
- Develop a comprehensive, sustainable government and private sector plan that addresses the long history of unequal racial treatment.

Suggested Readings

Bronfenbrenner, U. and Morris, P. (2006). The bioecological model of human development. In R.M. Lerner and W. Damon (Eds.), *Theoretical Models of Human Development*. Vol. 1 of the Handbook of Child Psychology (5th ed.). New York: Wiley.

Jablonski, N.G. and Chaplin, G. (2000). The evolution of human skin coloration. *Journal of Human Evolution*, 39(1): 57–106.

Lamason, R., et al. (2005). SLC24A5, a putative cation exchanger, affects pigmentation in zebrafish and humans. *Science*, 310(5755): 1782–86.

---

[1] The National Survey of American Life (NSAL) is a study designed to explore racial and ethnic differences in mental disorders, psychological distress, and informal and formal service use from within the context of a variety of presumed risk and protective factors in the African-American and Afro-Caribbean populations of the United States as compared with White respondents living in the same communities. The NSAL is part of the Collaborative Psychiatric Epidemiology Surveys (CPES) data collection (see ICPSR20240). Data and documentation for NSAL can be accessed through the CPES Web site.

Aging and Health among Hispanics/Latinos in the United States

Presenter: Kyriakos "Kokos" S. Markides, Annie and John Gnitzinger Distinguished Professor of Aging and Director of the Division of Sociomedical Sciences, Department of Preventative Medicine and Community Health, University of Texas Medical Branch

Moderator: Richard Schulz, Professor of Psychiatry; Director, University Center for Social and Urban Research; Director of Gerontology; and Associate Director, Institute on Aging, University of Pittsburgh

The U.S. Census Bureau recently reported that the Hispanic population in this country grew by 43 percent over the past decade and now exceeds 50 million, or 1 in 6 of the total population. This number is projected to double by 2050. Clearly the health characteristics of this group will have a major impact on the well-being of families, youth,, and the elderly in the United States.

The Hispanic population, especially the Mexican American population, which constitutes more than 65 percent of U.S. Hispanics, has experienced an increase in life expectancy in recent years that is larger than the general population, despite being an underprivileged group. Although the life expectancy of Hispanics is increasing, they tend to have more health disparities. While disparities are decreasing for other groups of color, they are on the rise for Latinos. A large percentage of older Hispanics have health insurance. However, they are still a population in which serious illness and disability are widespread. Many younger Hispanics lack health insurance or Medicaid, despite being among the poorest people in the country. There are various theories as to why Hispanics, particularly Mexican Americans, have the greatest increase in life expectancy but still suffer disproportionately from mental and physical illness. It is believed that the cultural aspects of the racially homogenous neighborhoods in which most Hispanics find themselves may have some health benefit to them. To decrease the prevalence of health issues in Mexican Americans and other Hispanics, we need to find ways to make these racially homogenous neighborhoods safer, more economically viable, and better situated to facilitate physical fitness.

The Problem

The Hispanic (Epidemiological) Paradox

The Hispanic paradox, also referred to as the epidemiological paradox, refers to the situation in recent years in which Hispanics in the United States, especially Mexican Americans, have had a larger increase in life expectancy than that of the general population but at the same time are a very underprivileged group with increasing physical and mental health problems. Some of the health disparities in the Hispanic population include the following:

- High rates of diabetes
- High rates of obesity
- Similar rates of hypertension and high cholesterol
- High smoking rates among men; women smoke fewer cigarettes than men;

> Cuban American males smoke the most

- High alcohol (binge) drinking rates among men, low among women; alcohol consumption in women increases with acculturation
- Low rates of physical activity

Other characteristics of Hispanics that affect health in a more positive way are culturally strong family structures and the fact that, as immigrants, they have successfully passed selection criteria for entering the country.

Projected Rates of Disability for Hispanics and Others

- Older Hispanics as a group will have greater disability rates than older non-Hispanic Whites—rates that are only slightly lower than those for African Americans.
- Older Asians and Pacific Islanders will have disability rates that are somewhat lower than those of older non-Hispanic Whites.
- Older Native Americans (American Indians and Alaska natives) will have high disability rates—possibly higher than any other population.
- Among the Hispanic populations, older Puerto Ricans will have the highest disability rates, with older Cubans having the lowest and Mexican Americans having intermediate rates.
- Among older persons of Mexican origin, the foreign born, especially men, will have lower disability rates than the native born.

It is not clear what rates for older Central Americans and older South Americans would be like, given the absence of guidance from existing literature. We might hypothesize that because these groups are overwhelmingly immigrants, their rates might be somewhat lower than rates for Mexican Americans if indeed they are selected through migration. Given that men are more likely to be selected than women, men will have lower disability rates.

It also is not clear what the rates for other Hispanics might be like. Other Hispanics are a heterogeneous mix of Spaniards, Dominicans, and perhaps some Filipinos as well as more than a few Mexican Americans, Puerto Ricans, Cubans, and persons of mixed ancestry who fail to identify with a specific Hispanic origin in their responses to the U.S. Census. Given this mix, we might expect them to exhibit average disability rates, perhaps similar to those for Mexican Americans.

Causes

It is theorized that the epidemiological paradox exists because of the large number of Hispanics who are immigrants. Immigrant populations across the world tend to be healthier people. They are physically and emotionally apt to overcome the barriers that may exist to moving to another country. They are usually motivated to make profound changes for themselves or their families in their new countries. Immigrants who do not face barriers of a selection process when migrating to another country are not as physically and mentally fit as those who face obstacles of a selection process when entering a new country. Those who enter the United States illegally and

populations who migrate here freely, like Puerto Ricans, who are citizens of a U.S. commonwealth, are not as healthy as those immigrants who face a selection process to gain entrance into the United States. Also, the health of immigrants tends to worsen the longer they stay in the United States.

The Salmon Bias Hypothesis

There has been evidence that some immigrants prefer to go back to their native countries when it is time to die. Because this is like a salmon going to its place of birth to die, it is called the salmon bias hypothesis. There is some truth to this hypothesis: Foreign-born social security beneficiaries living abroad had higher mortality rates than foreign-born beneficiaries living in the United States. However, the number of people who do migrate back to their native countries is relatively small. This small number would not account for the difference in mortality that exists between Hispanics and the general population. The salmon bias hypothesis also is offset by the number of children who move from their countries of birth back to the United States to be near any children or family members who may be there. While there is considerable return migration back to Mexico, data from the Mexican Health and Aging Study show that the vast majority of return migrants are younger. Very few older people return to Mexico because their children live in the United States.

Infant Mortality

Hummer and colleagues (2007) examined infant mortality rates among Hispanics and compared those rates to others. Their results showed that first-hour, first-day, and first-week mortality rates of infants born in the United States to Mexican immigrant women are about 10 percent lower than those among infants of non-Hispanic, White U.S.-born women. Furthermore, infants born to U.S.-born Mexican American women exhibited rates of mortality equal to those of non-Hispanic White women during the first weeks of life. In both cases, these infants fared better than those born to non-Hispanic Black women, with whom they share similar socioeconomic profiles. These fairly consistent patterns support the idea of an epidemiological paradox.

Health Characteristics of Mexican American Households

The study by Hummer et al also showed patterns of decreased health status over time for Mexican Americans and suggested a strong emphasis on education and continued monitoring. Trends suggest that prevalence of hypertension, diabetes, cognitive impairment, and the percent reporting daily living activities disability will increase over time in Mexican Americans age 75 and older.

On a positive note, 92 percent of older Mexican Americans living in the Southwest have medical insurance through Medicare, making them one of the most insured older populations in the United States. However, younger Mexican Americans are one of the most uninsured groups. This accentuates the importance of working now to help future generations of Mexican Americans, as well as other at-risk populations, to attain and maintain positive health outcomes.

Neighborhood Composition and Health Among Hispanics

Hispanics benefit from the cultural aspects of living in racially homogenous neighborhoods, like being among people who speak the same language, eat the same foods, and practice the same religions. Living in a majority Hispanic neighborhood possibly could have some positive health effects. Mexican Americans who live in homogenous neighborhoods often experience lower prevalence of stroke, cancer, hip fracture, and mortality within seven years. The incidence of breast, colorectal, and lung cancer among Hispanics increased as the percentage of Hispanics in the census tract decreased. The lower cancer rates among Hispanics relative to non-Hispanic Whites may dissipate as Hispanics become more assimilated into the mainstream society.

There are drawbacks to these more homogenous Hispanic communities as well. For example, they often lack sidewalks, recreational facilities, and safety.

Solutions

We need to create better communities for Hispanics that promote health and physical activity. This includes safe neighborhoods that accommodate and facilitate healthy living. We also need continued monitoring and research in order to develop effective educational programs and other interventions.

Suggested Reading

Hummer, R.A., Powers, D.A., Starling, G.P., Gossman, G.L., and Frisbie, W.P. (2007). Paradox found (again): Infant mortality among the Mexican-origin population in the United States. *Demography*, 44(3): 441–57.

Keeping America's Promise to All of Our Children

Presenter: William C. Bell, President and Chief Executive Officer, Casey Family Programs

Moderator: Marc Cherna, Director, Allegheny County Department of Human Services

Disparate treatment exists for children of color within the child welfare system. Permanent and stable families have positive and long-lasting effects on the lives of children. Conversely, the lack of a stable home can be detrimental in the lives of children and affect them in a negative way in adulthood. America always has had some response to issues of child welfare in society. In the country's infancy, many of the strategies for dealing with issues of child welfare may have exacerbated the problem or were intentionally noninclusive of all races. Child welfare policies and practices have continually evolved to adapt to the ever-changing landscape of American society. While children have become a federally protected group in the United States, much disproportionality in the children who enter the child welfare system still exists today.

The Problem

African American children make up 14 percent of the U.S. child population but 33 percent of the population of the children in foster care. White children make up 56 percent of the children in America but only 40 percent of the children in foster care. Black children stay in foster care for longer periods of time, experience more moves from foster home to foster home, receive less developmental and support services while in foster care, are less likely to be reunited with their families, and are more likely to age out of foster care without finding a permanent home than children of any other race. Each year, more than 700,000 children spend at least one day in foster care.

In 2008:

- eight out of every 1,000 African American children entered foster care,
- four out of every 1,000 Hispanic children entered foster care, and
- three out of every 1,000 White children entered foster care.

If we do nothing, by 2020:

- 5.5 million more children will be in foster care,
- 1.8 million of these children will be African American, and
- 115,000 more children will age out of foster care at age 18.

Causes

Distinct periods in history have had different responses to child welfare and specifically to children of color within the child welfare system.

Colonial Period

- No children of color were in the child welfare system. Any social response to the needs of African American children during this time was not considered because they were slaves. Poverty was considered a main factor for children in need of care by the child welfare system in place, which primarily involved moving poor children into families with land where they could be of service.
- White children were seen as the deserving poor, though their parents were undeserving.
- Children were removed from undeserving parents.
- African American children were property.
- Poorhouse Reform Era (1850–80)
- African American children still were not considered in the response system in child welfare.
- People started to believe that poorhouses were not places where children belonged.
- Children were removed from their families in the poorhouse and placed into indentured servitude.
- Children's aid societies were established. In 1853, philanthropist Charles Loring Brace founded the Children's Aid Society (then called "the Society") as an organization that found families for orphans and homeless youths among the pioneer families that were then just settling into the American West. Brace felt that living among these families would be a better alternative than living on the streets or in jails, almshouses, or orphanages.
- There was an increase in the number of orphanages.
- Family-based services were established.
- "Family breakup" was a child welfare response that resulted in the removal of children ages 2–16 from their homes to be placed in some sort of indentured servitude.

This era represented a time when Black children were disenfranchised. In addition, states began to enact their own policies regarding Black children in the child welfare system. For example, Alabama law allowed parents to be deemed unsuitable by the state. Their children then could be removed from the home and indentured back to former slave owners.

The Progressive Era (1880–1930)

- Concern for child abuse/cruelty to White children began to rise.
- People began to see that removing children from homes due to poverty could be problematic.
- The 1909 inaugural White House Conference on the Care of Dependent Children, held by President Theodore Roosevelt, commenced. This group opposed the institutionalization

of dependent and neglected children and determined that poverty alone should not be grounds for removing children from families.
- The 1912 Children's Bureau was formed to investigate and report matters affecting the welfare and lives of children.
- In 1913, President Woodrow Wilson enacted an executive order that resegregated all federal offices. Before this, federal offices had been integrated for almost 50 years. This move by Wilson effectively negated the possible positive effects of the Children's Bureau for Black Children because Blacks were forbidden to work in the same space with Whites on issues that affected their community.
- From 1916 into the 1940s, the "Great Migration" of 1.5 million African Americans from the rural South to the urban North took place.
- White children were protected.
- Black children were separate but somewhat equal.

The Rise of Federal Involvement in Child Welfare (1930–70)

- The focus on helping and protecting children greatly increased.
- The federal government took a more involved role in the child welfare system with the Social Security Act of 1935 (Title IV-B and Aid to Families with Dependent Children enacted). Title IV-B appropriated federal block grants to state public welfare agencies for the purpose of establishing, extending, and strengthening child welfare services. The language of IV-B was about delinquency and focused on protecting society from problems that came from the failure of parents. Aid to Dependent Children (ADC) was a federal assistance program that provided financial assistance to children whose mothers lacked the support of a breadwinner, no matter how they had gotten to that position. People believed it was better to provide aid to struggling mothers so that children could have the opportunity to be raised within their own families.
- Some states removed kids from ADC because of their parents' behavior (e.g., parents had additional kids out of wedlock).
- In 1962, ADC changed to Aid to Families with Dependent Children, which was a federal assistance program that provided financial assistance to children whose families had low or no income. "Families" was added because it was believed that the original legislation discourage marriage.
- Children were removed from unsuitable parents. Children of color were removed more frequently than children of other races.
- In 1962, the term "battered child syndrome" was defined as a disease in which children are victims of any of the various forms of child abuse or neglect.
- In 1967, Congress amended the Social Security Act to make it mandatory for states to have a foster care system and allowed nonprofits to serve kids.
- Child welfare came from a punitive perspective, not from a nurturing perspective.

The Family Reunification/Family Preservation/Child Protection Era (1970–Present)

- Increased legislation was used during this time to address child welfare problems.
- Major federal policies were implemented.

- In 1976, 100,000 children were in out-of-home care. By 1980, that number had increased to 302,000 children.
- The Adoption Assistance and Child Welfare Act of 1980 emphasized getting kids back home and resulted in a decrease to 276,000 children in out-of-home care in 1985.
- The draconian 1986 drug laws about possession and use of crack impacted the African American family. Lengthy incarcerations rose rapidly, which increased out-of-home placement for African American children. By the year 2000, the number of children in out-of-home care had increased to 547,000 and 41 percent of those were African American.

Solutions

Culturally competent programs need to be implemented in communities in which the greatest number of youths enter the child welfare system. These programs need to value children in the context of the specific social problems that those families and communities face. In addition, case workers need to have manageable caseloads so that they are able to make caring and informed decisions about the placement of children within troubled families. Family group or team decision-making models should be used.
We need to have a greater reliance on kinship foster care. This would provide fewer moves and stronger bonds.

We need to have greater investment in frontline staff and supervision as well as cap the number of cases that each caseworker can carry, because more manageable caseloads are necessary for them to be able to make better decisions regarding the placement of children. Twenty-five percent of kids entering foster care leave within the first three months, so the question has to be did they really need to be in out-of-home care?

In addition, we should:

- Fully implement the Family Support Model from the U.S. Department of Health and Human Services' Promoting Safe and Stable Families Program. Family support services are community-based preventive activities designed to promote parental skills and behaviors that will increase the ability of families to successfully nurture their children, use resources and opportunities available in the community, establish supportive networks to improve the child-rearing abilities of parents, help to compensate for the increased social isolation and vulnerability of families, strengthen parental relationships, and promote healthy marriages.
- Empower communities with data.
- Urge communities to take communal ownership of the responsibility of giving vulnerable children and families proper care.
- Value children in the context of families, value families in the context of communities, and value everyone else's participation in the context of a community support network that is helping communities to care for their own.
- Facilitate and support families making decisions regarding their future in the child welfare system.
- Increase the involvement of fathers in the lives of children.

Disparities, Decision Paths, and Disproportionate Placement of Native American Children

Presenter: Terry L. Cross, Developer and Founder, National Indian Child Welfare Association

Moderator: Marc Cherna, Director, Allegheny County Department of Human Services

Historically, the federal child welfare policy for Native American children was to systematically remove children to destroy the culture. Placement into the child welfare system often has been used as a strategy to assimilate American Indians into American society and eliminate their way of life. Native Americans lead in a majority of all child well-being disparities. They also are among the poorest children in the country, with more than 35 percent of them living in poverty. Native American families in the child welfare system receive very few poverty reduction services, housing-related services, mental health services, or substance abuse treatment services. In order to change the prevalence of Native Americans in the child welfare system, there has to be an increase in research to better understand the problems and the dynamics that cause them. In addition, measures need to be taken to reduce poverty in Native American communities and increase community-based services that are child centered and family driven.

The Problem

Child Well-being Disparities

KIDS COUNT DATA	Total	White	African American	Asian and Pacific Islander	American Indian	Latino
Child death rate (deaths per 100,000 children ages 1—14)	22	20	31	15	29	19
Rate of teen deaths by accident, homicide and suicide (deaths per 100,000 teens ages 15—19)	50	48	63	28	92	47
Percent of teens who are high school dropouts (ages 16—19)	8	6	10	5	10	17
Percent of children in poverty	17	9	32	12	35	29

American Indian children lead in almost every category of well-being disparity. Native American children currently rank second in U.S. child death rates, with 29 deaths per 100,000 children ages 1–14. Also, Native American children rank first in rates of teen death, with 92 per 100,000;

percentage of teens who are high school dropouts (17 percent); and percentage of children living in poverty (35 percent). Although Native American children have a higher rate of poverty than children of any other group, Native American families account for only 1.3 percent of the families that receive Temporary Assistance to Needy Families.

Disparities vs. Disproportionalities

"Disparities" refers to the variation in rates at which persons of different groups experience social conditions. An example of disparity is that Native Americans experience higher rates of health problems, such as diabetes and obesity, than other racial and ethnic groups in the United States.

"Disproportionality" refers to the overrepresentation of specific groups within a system, such as the overrepresentation of Native American children in child welfare, particularly placement. Native Americans also are underrepresented in the preventive restorative services.

Behavioral Health in American Indians/Alaskan Natives

- The rate of alcohol-related deaths among Native Americans ages 15–24 is 17 times the national average.
- The suicide rate for Native American youths is three times the national average (10 times the national average for children placed transracially in the child welfare system).
- There is only one trained mental health provider for every 17,000 American Indian children.

Juvenile Justice in American Indians/Alaskan Natives

American Indian youth are represented at 2.4 times the rate of Whites in state and federal juvenile justice systems and in secure confinement. Also, incarcerated American Indian youths are much more likely to be subjected to the harshest treatment in the most restrictive environments. Pepper spray use, restraint, isolation, and death while in confinement appear to be grossly and disproportionately applied to or occurring among Indian youths. In the state of Montana, Native Americans make up 7 percent of the population. However, 70 percent of the girls in secure confinement are Native American. Almost none of the Native American girls in secure confinement have committed a crime in society. They came into the system as truants and status offenders and were subject to harsher punitive measures due to acting out after entering the system.

Child Welfare Services for American Indians/Alaskan Natives

Indian families receive very few poverty reduction, housing-related, mental health, and substance abuse treatment services.

Causes

For more than 100 years, the "outing" systems of the 1850s and boarding schools from the 1870s to the 1970s were used to remove Native American children from their families and destroy their way of life. There also was a systematic removal of tribal authority over children during the 1950s. This was the era of transracial adoption, in which children were removed from Native American families without due process and placed in non-Native American homes across the East for the purpose of "saving" and "civilizing" the Indian. In addition, sterilization of Indian women occurred until the 1970s.

Decision Path to Disparity

For every 100 White children reported to child welfare in the United States, 25 cases are substantiated and eight are actually placed in the system. For every 100 American Indian children reported, 50 cases are substantiated and 25 are placed. Once placed, American Indians are twice as likely to enter the juvenile justice system.

Potential Factors for the Overrepresentation of American Indians and Alaskan Natives

Overrepresentation of American Indian and Alaskan Native children in care is related to poverty, poor housing, untreated mental health issues, and caregiver substance misuse. In Nova Scotia, Canada, 95 percent of children removed were from families with total incomes below $25,000.

Solutions

- Research to better understand the problems and the dynamics that cause them
- Reduction of poverty
- Community-based services that are child centered and family driven
- Cultural competence among professionals, organizations, and systems and within community work and treatment

Organizational cultural competence is a set of congruent practice skills, attitudes, policies, and structures that come together in a system, in an agency, or among professionals and enable that system, that agency, or those professionals to work effectively in the context of cultural differences. The elements of cultural competence are:

- awareness and acceptance of difference,
- awareness of one's own cultural values,
- understanding the dynamics of difference,
- development of cultural knowledge, and
- ability to adapt practice to fit the cultural context of the family

Policy and Practice Recommendations for Responding to Structural Risk Factors

There need to be strategies for responding to structural risk factors. Also, these strategies need to differentiate between maltreatment and social disadvantage. Services need to be better aligned with structural risk factors and the culture of children and families.

The Indian Child Welfare Act (ICWA) of 1978 shows that these problems cannot be legislated away. Not all children are covered by ICWA.

Approaches to Reduce Disproportionalities

- Training for mandatory reporting
- Differential response/diversion programs
- Greater use of tribal services
- Tribal capacity building for safety assessment and in-home services
- Parental involvement—navigators, volunteers
- Systems of Care Model (North Dakota Sacred Child)—culture and language
- Holistic approach
- Structural interventions
- Nondiscrimination

Sponsors

Race in America: Restructuring Inequality was generously supported by the following organizations:

GOLD Sponsors

Richard King Mellon Foundation
The Heinz Endowments
The Pittsburgh Foundation

SILVER Sponsors

BNY Mellon
Staunton Farm Foundation
UPMC

BRONZE Sponsors

The Buhl Foundation
EQT Corporation
Falk Foundation
Ford Foundation, Institute of International Education, Inc.
Highmark Blue Cross Blue Shield
Jewish Healthcare Foundation
PNC Financial Services Group, Inc.

UNIVERSITY OF PITTSBURGH Sponsors

College of General Studies
Computing Services and Systems Development
Division of Student Affairs
Graduate School of Public and International Affairs
Graduate School of Public Health
Learning Research and Development Center
Office of Institutional Advancement and the Pitt Alumni Association
Office of the Provost
School of Arts and Sciences
School of Dental Medicine
School of Education
School of Health and Rehabilitation Sciences
School of Information Sciences
School of Law
School of Medicine
School of Nursing
School of Pharmacy

Swanson School of Engineering
University Center for International Studies
University Center for Social and Urban Research
University Honors College
University Library System
University of Pittsburgh at Bradford
University of Pittsburgh at Titusville

NATIONAL UNIVERSITY Sponsors

Boston College, Graduate School of Social Work
Bryn Mawr College, Graduate School of Social Work and Social Research
Case Western Reserve University, Mandel School of Applied Social Sciences
Fordham University, Graduate School of Social Service
Howard University, School of Social Work
Rutgers, The State University of New Jersey, School of Social Work
University of Buffalo, School of Social Work
University of Georgia, School of Social Work
University of Houston, Graduate College of Social Work
University of Illinois at Chicago, Jane Addams College of Social Work
University of Kentucky, College of Social Work
University of Maryland, Baltimore, School of Social Work
University of Michigan, School of Social Work
University of Texas at Austin, School of Social Work
University of Washington, School of Social Work
Washington University in St. Louis, George Warren Brown School of Social Work

ADDITIONAL Sponsors

The Anderson-DuBose Company
Three Rivers Community Foundation