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'From Badness to Sickness' and Back Again: The Use of Medication in the U.S. School and Foster Care Systems

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Sarah Nemetz

"Whoa. It's sterile. It looks like a hospital."
"It has windows though—that's new."

As my friends and I walk into the newly minted multi-million dollar building on our first day of high school we notice the shine. The glare of the sun off of the pure white cement walls that bounces once again off of the spotless floors. The ground squeaks as we walk through.

After spending a whopping $197 million, my hometown of Newton, Massachusetts opened a brand new high school for the North side of town. My graduating class became the first to attend all four years in the new building, described by citizens and students alike as huge, sunlit, airy—and generally more conducive to learning than the previous institution. The old building was notorious for having very few windows—and in turn, limited access to sunlight—small cramped hallways, and a heavier, darker atmosphere. This is no coincidence, as it was designed in the 1970's by an architect who specialized in designing jails.

After a long internal fight, the predominantly white and upper-class city of Newton decided to tear the school-jailhouse down. But this crossover between schools and prisons is not one that has been banished by most communities in the United States, especially those that contain a larger number of non-white students. In fact, as a troubling number of school shootings plagues the news cycles, political discourse around how to treat and patrol our students has progressively entered the spotlight.

The year of 2018 saw events and activism that brought the issue of school shootings to the forefront of national politics. Since the town of Parkland, Florida was traumatized by a school shooting in February of 2018, student activists have taken it upon themselves to lobby for stricter gun control laws, as their representatives have failed to do. On the other hand, some politicians, including President Donald Trump, are attributing the problem not to loose gun control laws but to poor mental health policies in schools, and consequently, unstable and troubled students left to their own devices. They claim that the solution lies in the arming of teachers to gain more direct and immediate control over these dangerous and unstable students.

Though Trump's position is somewhat misguided by alterior political motives, he has brought an important issue into the public eye: the mental health of youth and how we treat it in the school system. However, Trump's performed concern for this matter has provoked criticism that a double standard exists across racial lines, since mental health

concerns are not extended towards youth of color who misbehave or are seen as disobedient. This raises a larger question: how are we dealing with mental health and other disabilities among youth, and specifically youth of color, in our institutions?

In this paper, I explore how medication plays a role in the treatment of learning disabilities in the public school system and mental health disorders in the foster-care system, and how these two processes differ. Based on this comparison, I analyze the racialized, classed and gendered implications of the relationship between the medicalized practices in the two institutions.

The School-to-Prison Pipeline

The issue of medication in schools and in the foster care systems are part of a larger national discourse that falls under the umbrella of a term or trend called the school-to-prison pipeline. The school-to-prison pipeline is the system in the U.S. in which students, predominantly students of color, are funneled from public schools into prisons. This funnelling occurs because students are criminalized in the school system by zero-tolerance policies and police monitoring in the hallways. In this system, students that engage in infractions and behaviors that could be handled inside school walls are pushed out of school, with their actions deemed criminal and dealt with accordingly.[2] This process places students in the hands of the criminal justice system long before they are of age and often before they engage in true criminal behavior.[3]

This paper explores not only the use of medication in schools, but also engages with the foster care system. Though not directly part of the pipeline, the foster care system connects directly to schools, as both work with students to ensure their academic success and general well-being until they are 18 years old. In addition, youth of color, especially black and Native American kids, are disproportionately represented in the child welfare system.[4] That being said, it is crucial to engage with both institutions when discussing treatment of youth and youth of color in the United States.

Medication in Discourse

Medication in the school system can mean very different things for students depending on race, geography, and class. For example, a middle-class student in a suburb of Boston will have different interaction with and accessibility to medication than a low-income student in the heart of Los Angeles. Students' personal and environmental backgrounds may also play a large role in this relationship to medication. Because of this, the use of medication is a crucial factor in what may separate students' experiences in the institutions that hold youth—and what may potentially contribute to some students being pushed into the

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[2] "School-to-Prison Pipeline," ACLU, accessed 7 April, 2018, https://www.aclu.org/issues/juvenile-justice/school-prison-pipeline.

[3] Ibid.

[4] "Racial disproportionality and disparity in child welfare," U.S. Department of Health and Human Services, Children's Bureau, 2016, https://www.childwelfare.gov/topics/systemwide/cultural/disproportionality/.

school-to-prison pipeline while others stay in the "cradle to college pipeline." The cradle to college pipeline is a term that describes the alternative to the school-to-prison pipeline: instead of pushing students from the school system into the criminal justice system, this pipeline directs youth from birth towards college. These youth receive support and encouragement to this end throughout their time as a minor.[5]

It is common for youth to be affected by many types of disorders or disabilities: academic, behavioural (ADHD, most commonly), or other mental or emotional disorders like anxiety or depression. However, arguments about how institutions deal with these disorders vary. The most common argument within literature on the school-to-prison pipeline is that due to racial biases in schools, white youth tend to be medicated for their issues while youth of color are criminalized—meaning they are punished or tracked into special education or even pushed into the criminal justice system. This process points to an overarching issue that youth of color are undermedicated for their problems.

When considering the foster care system that is so closely tied to the school system, however, an alternative argument is present: there is heavy over-prescription of medication to youth. Overuse of psychotropic medication in the foster care system is a problem that many states have acknowledged, but it seems to often be ignored in the school-

to-prison pipeline dialogue due to its perception of dissociation from the school system.

So which argument is correct: under- or overuse of medication? I argue that both arguments are valid: under-medication and over-medication are both prevalent within the school-to-prison pipeline, but they are used in different institutions and for different types of disabilities and disorders. Based on the existing literature, youth of color are under-medicated for their academic standing or disabilities in schools but over-medicated for mental health or emotional disorders in the foster care system. For example, a black student in foster care is more likely to be deprived of medication for ADHD and instead tracked into special education than a white student. Black students, however, are more likely to be given psychotropic medication for anxiety by a counselor or other caregiver in the child welfare system. I argue that this two-pronged system points to a layered prejudice concerning black and brown youth's academic versus emotional capabilities. While under-medication and over-medication are opposite approaches, they both serve as a form of social control.

I first define the terms social control and social deviance and discuss the general medicalization of our society since the 1960's. Next, I explain the process of diagnosing students in schools for different types of disorders. I then explore in more depth the use of under-medication in schools and over-medication in the child welfare system. I conclude by analyzing how the medicalization in these two institutions interacts within the

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[5] "Cradle to College Pipeline Summit," *National Economic & Social Rights Initiative*, accessed 8 April 2018, https://www.nesri.org/events/2010/cradle-to-college-pipeline-summit.

school-to-prison pipeline, and how this affects the well-being of students of color.

Social Control and Social Deviance

The idea of social control first emerged through early social philosophers like John Locke, Thomas Hobbes, and Jean-Jacques Rousseau and has since extended to many different fields, though the concept finds its most relevant home in sociology.[6] Social control is the sociological phenomenon which explores how institutions in our society—including the government, religions, and schools—maintain social order. The ultimate goal of social control is the conformity of individuals to the established social norm.[7] Social control typically targets those that society or the institution deems to be deviant, disobedient or undesirable.

So how do society and societal institutions decide who is deviant? In the United States, the social norm has been established as white, male, heterosexual, financially well-off, and adult—even just having the status of a youth is "othering."[8] Therefore, youth in schools are already seen as inherently deviant and are scrutinized as such. Having an additional "othered" status, like identifying as black or Native American, female, or LGBTQ, subjects a student to even more scrutiny and policing of socially deviant

behavior. The "socially deviant" behaviors that are criminalized or medicalized in the school and foster care system are behaviors that are outside the norm of this ideal—meaning, behaviors that read as non-white, queer, or low-class immediately classify a student as deviant, and therefore, a possible criminal.

These are important concepts to keep in mind when considering the diagnosis of students and the prescription (or lack of) of medication to youth in the school and foster care systems.

History of Medicalization

Scholars have engaged with the medicalization of our society since the 1960's, and many take a critical view.[9] Medicalization is the process in which previously nonmedical problems become defined and treated as medical illnesses or disorders. Some of the illnesses or disorders that were medicalized include ADHD, alcoholism, and menopause. Some of these problems, like menopause, involve simply acknowledging a medical cause and developing a treatment for a natural occurrence in the human body. Other medicalized problems like anxiety or mood disorders, menstruation, and infertility are conditions that people are born with or develop and involve a difference in their chemical or biological makeup.

However, medication is also applied to conditions that often develop due to social or environmental factors. Social environments or traumas like child abuse, sexual abuse, or

[6] Jason Carmichael, "Social Control," *Sociology*, Oxford Bibliographies, 15 February 2018, www.oxfordbibliographies.com/view/document/obo-97801 99756384/obo-9780199756384-0048.xml.

[7] Ibid.

[8] Nancy A. Heitzeg, "'Whiteness,' Criminality, and the Double Standards of Deviance/Social Control," *Contemporary Justice Review* 18, no. 2 (2015): 197-214, doi: 10.1080/10282580.2015.1025630.

[9] Peter Conrad, "Medicalization and Social Control," *Annual Review of Sociology* 18, no. 1 (1992): 209–32, doi: 10.1146/annurev.so.18.080192.001233.

neglect can play a role in the development of a condition which could include mental disorders, drug addictions, eating disorders, or learning disabilities. These types of conditions or disorders are often shrouded in stigma and shame, and they are generally viewed in a negative light. According to sociologist Peter Conrad, "behaviors that were once defined as immoral, sinful, or criminal have been given medical meaning, moving them from badness to sickness."[10] Due to their ambiguous root causes, these types of conditions are often less cut-and-dry in whether or not medication is the proper treatment.

The movement of medicalization in the 1960's occurred for many reasons, some being the decrease in prevalence of religion, the strengthening of faith in science and the medical profession, "the American penchant for individual and technological solutions to problems," and the increase in the amount of social or humanitarian movements.[11] The medicalization of alcoholism and post-traumatic stress disorder, for example, were the result of social movements and increased social awareness, rather than the sole actions of physicians.

Medicalization has had a massive effect on the social society of the United States. In many ways, it makes life more manageable by providing cures or treatment for people who suffer from disorders, illnesses, or pains that the medical field once failed to acknowledge. This will be an important point to keep in mind throughout this piece: medication is

truly a saving grace for many people who suffer from mental illnesses and other social disorders, without which day-to-day functioning might be impossible.

That being said, like with any change in the technological makeup of a society, the increase of medication as treatment has its drawbacks. Medicalization tends to individualize and decontextualize problems—it tries to fix the issue by fixing the individual, instead of looking at larger societal problems. This can be problematic when examining institutions like school and foster care. When considering learning disabilities, for example, many argue that medicalizing progress in school ignores the effects of factors like social practices and hierarchy on students' academic standing. And in turn, medicalizing places the blame of an academic or behavioral shortcoming on the individual student, potentially leading that student to believe that there is something inherently wrong with them. This process of individualizing and minimizing social issues is one way in which the school exerts social control over young people. It is easier to tell a student that they have a learning disability than to explain why, for example, they are behind in school because of their family's financial shortcomings or lack of support at home.

A common research topic is the medicalization of deviant behavior. Behavior that was once seen as socially deviant, or separate from the norm, is now treated as a medical problem that can be treated or cured. Within the school-to-prison pipeline, this is most common with the diagnosis of hyperkinesis, or ADHD. Child behavior like

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[10] Ibid, 209-32.
[11] Ibid, 209-32.

hyperactivity, restlessness, and inability to pay attention used to be viewed as a poor habit but is now seen as a medical disorder.

Medication for disorders like this can act as a form of social control, as "psychoactive drugs, especially those legally prescribed, tend to restrain individuals from behavior and experience that are not complementary to the requirements of the dominant value system."[12] In fact, ADHD is also a good example of individualizing problems. When typical discipline fails to work with hyperactive students, medication is prescribed and their behavior starts to conform to normal social standards. However, prescribing that medication dismisses the possibility that certain behavioral problems are not medical issues, but rather reactions to a social situation or structure.

The Public School System: ADHD and Under-Medication of Students of Color

"*Do you think I should do it? I need at least a 2250 this time around.*"

"*Definitely. Connor took the SAT two months ago on Adderall and he got like 100 more points. I think he got it from Emma, I'm sure she'd sell you some.*"

Adderall is often referred to as the "study drug." It is commonly prescribed for ADHD, or Attention Deficit/Hyperactivity Disorder. Many students need Adderall to focus in class, get through the school day, and complete their homework. However, Adderall is frequently used for other purposes. Though almost all of the literature on the use and abuse of this drug is about college campuses,[13] in my predominantly white and upper-middle class high school, conversations like the one above were common. The drug rode rampant as a way to combat late-night study sessions, SAT sittings, and was sometimes even used recreationally to let off steam on the weekends. In this context, medication may be viewed by many students as a way to get ahead in classes and to further progress through the cradle-to-college pipeline. In the discussion of ADHD use in the school system, we must consider how class, gender and race affect who has access to this medication, and how it is used.

In the discussion of behavioral disorders like ADHD and its subsequent medication, there is still controversy over whether or not ADHD is a disease or a "sociocultural construct."[14] This makes it extremely difficult to establish which child is truly in need of ADHD medication for their day-to-day responsibilities. It is, again, important to note that the medicalization of ADHD and other types of behavioral disorders is necessary for some students to be able to succeed in school when they suffer from symptoms. The problems arise when students of different races, classes, and genders are diagnosed by different standards. Due to this

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[12] Peter Conrad, "The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior." *Social Problems* 23 no.1 (1975): 12–21. doi:10.2307/799624.

[13] Jason Besser, "Do We Have an Amphetamine Problem on College Campuses?," *The National Center on Addiction and Substance Abuse*, last modified October 3, 2017, www.centeronaddiction.org/the-buzz-blog/do-we-have-amphetamine-problem-college-campuses.

[14] Lillian Dowdell Drakeford, *The Race Controversy in American Education, Vol. 1: Racism in American Institutions* (Santa Barbara, CA: Praeger, an Impr. of ABC-CLIO, 2015), 135.

ambiguity, it is important to understand the general proceedings of diagnosis and the school's role in this process to further discern the larger implications of this issue.

The medicalization of hyperactivity as ADHD saw major growth in the past few decades. Before the 1970's, the rate of ADHD diagnosis was as low as 1% of all school-aged children, but by the 2000's it had jumped to approximately 8%.[15] This change was due to changes in the 1990's, namely the establishment of ADHD as a disability in the Individuals with Disabilities Education Act (IDEA), which made children eligible for accomodations in school; and changes in insurance policies to more widely cover psychotropic medications, which made them more accessible.[16] In the 1990's, the prescription of methylphenidate, more commonly known as Ritalin or Concerta, rose by 500% while the prescription of amphetamines like Dexedrine rose by 2,000%.[17]

While school staff do not directly diagnose students, they are a major catalyst for these diagnoses. Parents or guardians of the students have their children tested and medicated, but teachers and administrators almost always guide families to frame hyperactivity or conduct issues as medical problems. A survey conducted in the greater Washington, D.C. area in 2003, inspired by the

concern that these medications were over-prescribed, found that teachers and other school personnel were most often the first to suggest diagnosis of ADHD compared to parents, primary care physicians, and child psychiatrists/psychologists.[18]

Schools also control the movement of students who have been diagnosed with a medical disorder. Once they are referred for testing, students have to qualify under IDEA and Section 504 of the Rehabilitation Act of 1973. Under these laws, if students fit certain criteria of symptoms for medical disorders that hinder educational progress, schools must make accommodations for them. Under IDEA, students must meet criteria for one of thirteen disability categories to qualify.

However, under Section 504, criteria is much more subjective and requires that students display "physical or mental impairment that substantially limits one or more major life activities."[19] According to Ramey, "major life activities" are often outside the realm of learning or problems that would affect classroom performance, such as some behavioral issues.[20] Overall, the qualifications for diagnosis and treatment within schools are subjective at their core, and the ultimate diagnosis often doesn't even require a doctor or psychiatrist's approval.

It is important to point out, however, that there is an additional cultural layer to diagnoses in schools. Though teachers may refer students to get tested for disorders, it is

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[15] Daniel F. Connor, "Problems of Overdiagnosis and Overprescribing in ADHD," *Psychiatric Times* 28, no. 8 (2011): http://www.psychiatrictimes.com/adhd/problems-overdiagnosis-and-overprescribing-adhd.
[16] Ibid, 1.
[17] L Sax, and Kautz KJ, "Who First Suggests the Diagnosis of Attention-Deficit/Hyperactivity Disorder?" *Annals of Family Medicine* 1, no. 3 (2003): 171–74.

[18] Ibid, 172.
[19] David M. Ramey, "The Social Structure of Criminalized and Medicalized School Discipline." *Sociology of Education* 88, no. 3 (2015): 181–201, doi:10.1177/0038040715587114.
[20] Ibid, 184.

the parents or guardians who ultimately carry out these referrals and have the final say on their minor's care. Research shows that families of black and hispanic children are less likely to credit their children's behavior to medical or mental health causes due to differences in cultures' relationships with and knowledge of medication and mental health.[21] Other cultural factors, including immigration status, language barriers, and general discrimination in schools, have left hispanic families—along with families of other backgrounds—very skeptical and distrustful of teachers' advice about their children's behavior or health.[22] There is little scholarship on the relationship of different cultures' perception of medication with prescription, so this is a question worth considering in future research: how does the parent or guardian play a role in who is treated with medication or otherwise?

Class is a key factor to include when considering who is prescribed ADHD medication and who has access to it. As mentioned above, typically schools in higher-income areas have higher rates of prescription along with misuse and abuse of prescription. Though this is partially due to the more obvious idea that paying for prescriptions is more feasible for people with higher incomes, this is also due to the No Child Left Behind Act (NCLB) of 2001 working in tandem with zero tolerance policies in schools. NCLB made standardized test scores

the assessment for how much funding a school received.

According to education researcher Lillian Drakeford, there are two main ways that schools could address their test scores: by diagnosing students with ADHD and by implementing zero tolerance policies. Providing accommodations to children with ADHD can help schools to raise their test scores; clearly, using ADHD diagnosis as a way to get ahead is not just beneficial to individual students but to school systems as well. Studies show that school districts with state laws that penalize schools for low test scores have higher rates of ADHD diagnoses.[23] On the other hand, zero tolerance policies were implemented, which pushed kids who were disruptive or non-compliant out of class; NCLB caused a major increase in suspensions and expulsions. Due to increased attention on test scores and achievement for schools' funding, class plays a major role in the way that youth are categorized and treated by our schools.

However, these same distinctions between zero tolerance policies and diagnosis are not just classed but racialized. Though black and hispanic youth are overrepresented in school discipline, they are underrepresented in IDEA or Section 504 plans that deal with behavioral disorders like ADHD—therefore, they are under-medicated compared to their white peers.[24] This disparity is due to the mindsets of teachers

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[21] Anthony J. Nocella, *From Education to Incarceration: Dismantling the School-To-Prison Pipeline* (New York: Peter Lang, 2014).
[22] Ibid.

[23] Lillian Drakeford, *The Race Controversy in American Education* (Praeger, an Impr. of ABC-CLIO, Santa Barbara, CA, 2015).
[24] David M. Ramey, *The Social Structure of Criminalized and Medicalized School Discipline, Sociology of Education*.

and administrators on the difference in factors of misbehavior between minority and white youth. Many studies have shown that there is a racial disparity in diagnosis of ADHD and that school officials are most likely to see white boys as candidates for medication. This mindset stems from our society's idea that white, male, and financially well-off is the "norm"—this implies that if a white boy deviates from that norm (namely, he doesn't excel academically or misbehaves in class) then the school treats his shortcomings as a medical issue, which is viewed more positively than its alternative: suspension, expulsion, and general criminalization.[25]

On the other hand, youth of color are not given this benefit of the doubt, and their shortcomings are met with the wrath of zero tolerance policies that push them out of schools instead of supporting them to reach the finish line like their white peers.[26] In a JAMA Pediatrics study, data show that "concerning race/ethnicity, African-American and Latino children were 0.59 and 0.46 times as likely to report past-year medication use compared to whites; Latino and Other children were 0.41 and 0.55 times as likely to report lifetime medication use compared to whites."[27]

The framing of whiteness and blackness directly relates to the distinction between medicalization and criminalization of "deviant" behavior in schools. Because whiteness is the norm, when a white student acts in a contrary way to those norms, teachers, administrators, and parents assume that there is an underlying medical problem at the root. On the other hand, blackness is already seen as an "other," so deviant behavior is expected and even accepted in a way: many teachers and administrators, with exception, treat black and brown youth's misbehavior as the product of poor character and consider their antisocial behavior innate. Therefore, it is handled with what seems like a quick-fix punishment in the hope of separating disruptive kids from the classroom. When teachers see youth of color acting out in class, even in the same ways as white youth, they believe that these kids are destined for criminal behavior and incarceration. Youth of color are viewed as having no hope, so long-term or comprehensive solutions for their problems, like medication, are substituted for immediate fixes that are designed mainly to alleviate hardship for teachers, administrators, or other students.

The Foster Care System: Over-Medication of Youth of Color

Though under-medication of youth of color is prevalent in schools, the issue of over-medication of youth must not be ignored. A majority of the documented cases of over-medication are in public health care facilities—more specifically, the child welfare system.[28] Unlike in the school system where

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[25] Lillian Drakeford, *The Race Controversy in American Education* (Praeger, an Impr. of ABC-CLIO, Santa Barbara, CA, 2015), 136.

[26] Lillian Drakeford, *The Race Controversy in American Education* (Praeger, an Impr. of ABC-CLIO, Santa Barbara, CA, 2015), 135.

[27] KR Merikangas, He JP, Rapoport J, Vitiello B, and Olfson M. 2013. "Medication Use in US Youth with Mental Disorders." *Jama Pediatrics* 167, no. 2 (2013): 141–48. doi:10.1001/jamapediatrics.2013.431.

[28] Though it is true that most over-medication literature is about the child welfare system, there is also some discussion in the public school system. In 2004, an amendment was

medication is largely prescribed for behavioral problems like ADHD, medication is typically distributed for mental health issues like depression or other emotional conditions in the child welfare system. However, it is a common trend and complaint among children in foster care that they are over-medicated within their system of social workers, therapists, or other authority figures.

In a 2013 JAMA Pediatrics study, researchers found that "children with involvement in public mental health were nearly three times as likely to report past-year use and lifetime use compared to those without involvement."[29] (In this context, the public mental health system is the child welfare system.) In 2011, the U.S.'s Government Accountability Office released a report that illuminated that the federal government was not doing enough to supervise the distribution of psychotropic medication— what they call "mind-altering drugs"—to foster children.[30] The report was based off of a two-year long study in five different states. The researchers found that foster care children, alarmingly as young as

one year old, were prescribed psychotropic medication at a rate nine times that of a typical U.S. child.[31] Some children were prescribed up to five different prescriptions at a time. Many other studies have found similar results.[32] This report preceded the passing of the National Improvement and Innovation Act of 2011 that aimed to establish federal oversight over the distribution of psychotropic medication to children in foster care.[33] However, there is still a strong need for accountability on the state and local level.[34]

In the discussion about over-medication of youth, it is important to acknowledge that youth who have been through the foster care system are in fact more likely to have mental health issues than those who have not.[35] Therefore, it may make sense that more of them are diagnosed with emotional conditions. However, that doesn't necessarily mean that more foster care kids should be medicated and that the problem of over-medication is invalid. In a study called *Experiences of and Attitudes Toward Mental Health Services Among Older Youths in Foster Care*, older youth in foster care who were getting ready to transition out of the system

added to IDEA called the Prohibition on Mandatory Medication Act. Before the amendment, it was possible for a child to be tested under IDEA and for the school to require the child to be medicated for their disorder. If they weren't, the school would threaten to hold them back in school, put them in special education, or others. This amendment addresses public schools pushing families and students into medication when they otherwise would not have chosen that route for their child or themselves.

[29] KR Merikangas, He JP, Rapoport J, Vitiello B, and Olfson M. 2013. "Medication Use in US Youth with Mental Disorders." *Jama Pediatrics* 167, no. 2 (2013): 141–48. doi:10.1001/jamapediatrics.2013.431.

[30] Mark Abdelmalek, et al."New Study Shows U.S. Government Fails to Oversee Treatment of Foster Children With Mind-Altering Drugs," ABC News Network, 30 Nov. 2011, abcnews.go.com/US/study-shows-foster-children-high-rates-prescription-psychiatric/story?id=15058380.

[31] Ibid.

[32] KR Merikangas, et. al., "Medication Use in US Youth with Mental Disorders," *Jama Pediatrics* (2011): 143.

[33] Franklin Law Group, "Over-Medication of Psychotropic Drugs & African-American Girls in Foster Care," Submission to the United Nations Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment, Fifty-Third Session, November 3-28, 2014. http://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/USA/INT_CAT_NHS_USA_18527_E.pdf

[34] Ibid., 6.

[35] Ellen Marrus, "Education in Black America: Is It the New Jim Crow?" *Arkansas Law Review* 68, no. 17 (2016): 27-54, accessed 8 April 2018, https://cpb-us-e1.wpmucdn.com/wordpressua.uark.edu/dist/0/285/files/2015/05/ArkLRev-68-1-27-54-Marrus.pdf.

were interviewed about their time in the mental health services and their relationships with the providers and mental health professionals. In the study, the most common complaint was that youth felt like they were being over-medicated. They felt that their counselors were not really listening in their counseling sessions and sometimes prescribed prematurely.

One minor stated that "Dr. B slapped meds on me the first day she met me. She didn't even take the chance to listen."[36] It was common for youth to feel like their psychiatrists thought medication was the only way to deal with their issues, and tried to manipulate them into using medication: "They try to drill it in my head that I need medicine." Youth felt that the use of medication was sometimes not only ineffective, but actually had a negative impact: "Doctor put me on [medication]. It messed me up, messed my brain up"; "They try to drug you up; you can't function."[37]

This is a concerning process in the child welfare system. Foster care children are some of the most vulnerable youth and many have faced extremely traumatic experiences; again, it is more common for them to have mental health issues than others in the school system. Pre-emptive medication and over-medication of youth by mental health professionals who have not taken the time to actually work with kids and try to understand the root of their problems or traumas is not

only largely ineffective but also shows a lack of consideration for their long-term well-being. Welfare kids are only in the system until they are 18, and there has not historically been accountability for performance outcomes of children after they leave the system.[38] Because of this, "quick-fix" solutions like medication are the easiest route to take for professionals working in public mental health facilities.

However, in this situation, medication is not a comprehensive solution to trauma, and in the long run, youth are not necessarily better off. Looking past the end of a child's time in the welfare system, the use of medication could potentially cause a future dependency that could lead to deeper problems down the road. It's also important to point out that when a child is in the welfare system, public facilities act as their parents—they are forced to trust the system to tell them how to best help themselves. If the welfare system fails to adequately address medication management, there is virtually no one else to advise a child to engage with medication or not.

This is not to say that the professionals in the child welfare system are solely to blame for the prevalence of over-medication. Over-work and heavy caseloads of professionals working with clients in foster care is widespread. With so many children to care for, it is easy to see why professionals may feel that they do not have the time to more properly discern if medication is the

[36] Lee, B. R., M. R. Munson, N. C. Ware, M. T. Ollie, L. D. Scott, and J. C. Mcmillen, "Experiences of and Attitudes Toward Mental Health Services Among Older Youths in Foster Care," *Psychiatric Services*, vol. 57, no. 4 (2006): 487-92.
[37] Ibid.

[38] Bruskas, Delilah. "Children in Foster Care: A Vulnerable Population at Risk." *Journal of Child and Adolescent Psychiatric Nursing*, vol. 21, no. 2, 2008, pp. 70–77., doi:10.1111/j.1744-6171.2008.00134.x.

correct route for a child. This is a way in which the system could adapt to address this issue structurally: if social workers or caseworkers in the foster care system had more manageable caseloads, these conditions may potentially improve.

How does race play into over-prescription in the foster care system? There is little evidence that children of color are over-medicated in comparison to their white peers in the child welfare system. However, the disproportionate rate of youth of color in the foster care system implicates many more black and brown children than white children. [39] According to statistics published in 2014 by the U.S. Census Bureau and the U.S. Department of Health and Human Services, 56.6% of children in the child welfare system were black, Native American, hispanic, Asian, and mixed-race while only 48.1% of the total child population were of this demographic.[40] This does not specifically point to a disparity of medication between races within the public health system. However, these disproportionate rates demonstrate crucial racial implications of the over-use of medication in the system.[41] When considering how youth are treated in institutions, the disproportionate number of black and brown children affected cannot be ignored.

The over-prescription of psychotropic medication is not just racialized but also gendered. A report submitted to the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) by The Franklin Law Group in 2014 calls for attention and special care for African American girls in the foster care system, as they are the most vulnerable group in the over-medication of children in the welfare system.[42]

While there is little quantitative data on the higher rates of prescription to black girls in the system, the report points out the fact that black youth are diagnosed with higher rates of mood and behavior disorders and that black girls are documented as having higher rates of depression. Additionally, the report cites the racist and sexist stereotypes attached to black girls, namely that they are angry and aggressive, which leads to mislabeling diagnoses. The study also asserts that the historical trauma that black girls carry with them through the foster care system, including the long history of bodily control and abuse, makes them more vulnerable to the inappropriate prescription of psychotropic medication and should have special protection because of "[their] heightened exposure to intersectional discrimination." It's important to note that there is only qualitative research on this topic,

[39] Child Welfare Information Gateway, "Racial disproportionality and disparity in child welfare," U.S. Department of Health and Human Services, Children's Bureau, 2016, https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf.
[40] Ibid., 3.
[41] Ellen Marrus, "Education in Black America: Is It the New Jim Crow?" *Arkansas Law Review* (2016), 32.

[42] Franklin Law Group, "Over-Medication of Psychotropic Drugs & African-American Girls in Foster Care," Submission to the United Nations Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment, Fifty-Third Session, November 3-28, 2014. http://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/USA/INT_CAT_NHS_USA_18527_E.pdf.

but the personal accounts of these girls alarmed the law group enough to submit a report to the United Nations.

All of this data points to the importance of taking an intersectional approach to mental health in the institutions that hold our youth. Race, class, and gender are all factors that clearly influence how children are treated and cared for in the foster care system, and this treatment follows them from foster care into the school system. Because of this, it is crucial to discuss both treatment in the foster care and school systems in the same discussion of treatment of both learning and mental health disorders.

The Intersections of School and Foster Care

Both the under-use of medication in schools in treatment of behavioral issues and the over-use of medication in the child welfare system treating emotional issues are clearly prevalent in their respective institutions. Though they seem like opposite approaches to similar problems, they are both forms of social control over predominantly youth of color. In schools, medicating white students and not doing the same for black and brown students perpetuates the idea of whiteness as normative and non-whiteness as deviant. When confronted with similar misbehavior, schools segregate students of color into special education, and criminalize them within school disciplinary measures, while they prescribe white students with medication. This system perpetuates the social norms that benefit whites and disadvantage the "others."

On the other hand, over-medication in the welfare system exerts control over students of color in another way: by "numbing" kids with medication rather than providing them with individual and personal attention and solutions. The act of "shutting them up" serves as social control, as it shapes children into acting in adherence with the social norm. This discussion brings up larger questions concerning how we consider the two interactions and their subsequent practices in relation to each other, the prejudices that this dichotomy of medication use presents, and the way that we consider more general mental health practices for youth of color.

Both the public school system and the foster care system (for a percentage of youth) are institutions that children are legally bound to while they hold the status of a child. One of the main goals of this discussion is to illuminate how we treat and hold the youth of color in terms of their academic and emotional well-being in institutions and systems tailored to a white, male, financially stable frame. While research, literature and activism around the school-to-prison pipeline work to redirect children into the cradle-to-college pipeline, the discourse lacks a consideration of the foster care system in black and brown youth's pursuit of success.

When the practices of over-medication and under-medication are so clearly pervasive in these institutions, we must stop considering them as two separate entities and start exploring how the practices and effects of each interact. Neither of these institutions exists in a vacuum: when a child leaves their

foster family or a meeting with their social worker in the morning and enters school, the former institution does not cease to exist, and vice versa. The care and treatment of a child crosses between the institutions they are a part of. Because of this, we must acknowledge and question how the practices surrounding medications affect how black and brown children see themselves.

The practices surrounding medication illuminate prejudices and assumptions about black and brown children that these institutions hold in their treatment of behavioral and mental health issues, and in their consideration of the trauma that these children hold as they move through the systems. What are we teaching youth of color about their own abilities to succeed in school and beyond their youth?

After examining the way that the medicalization of these two institutions act within the school-to-prison pipeline, it is clear that the two forms of social control point to a more nuanced paradigm than simply "whites get medicated and blacks get criminalized"—and this paradigm builds off of assumptions and prejudices about youth of color. When addressing academics, intelligence, and behavioral capability, schools assume that if a black or brown student is struggling, they do not have a disability but are innately less adept than their white peers. Therefore, they must be pushed out of the mainstream school system, lest the school's funding or classroom dynamic be negatively affected. A passage from Lillian Drakeford's book *The Race Controversy in America* stands out:

> Both black and Latino/Latina students are far less likely than their white peers to receive an ADHD diagnosis; ...if they are medicalized in the school context at all, it is with more stigmatizing labels of learning disorders that focus on intellectual ability rather than behavior.[43]

When white students are given medication for their disruptive behavior, they are given the encouragement and reassurance that their shortcomings in the classroom are easily fixed with a pill. With similar behavior, students of colors' intellectual capacities are questioned and discredited.

However, when dealing with emotional disorders or struggles stemming from trauma, as exemplified in the foster care system, youth of color are both incapable of handling their emotions and not allowed to showcase or feel their trauma. If those who work in the foster care system acknowledge the personal pain and trauma that their children live with, then what are we teaching children about their health and healing process by persistently medicating them? Are black and brown students not allowed to cry, not allowed to break down? It is true that medication can be part of a long-term and positive solution to an emotional disorder—but if we claim that medication is the answer to trauma, why don't we listen to youth of color, who live with the effects of trauma, when they say that it isn't?

In her work *Black Pain: It Just Looks Like We're Not Hurting*, therapist and author

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[43] Lillian Drakeford, *The Race Controversy in American Education* (Praeger, an Impr. of ABC-CLIO, Santa Barbara, CA, 2015), 136.

Terrie Williams utilizes her own and other black folks' stories to discuss the phenomenon of depression within the black community in the U.S. In her chapter "Oh Lord, Please Don't Let Me Be Misunderstood," she discusses black folks' relationship with mental health services. There is a history of distrust of health services, including mental health, among black people due to both the abuse the white health care system has put black people through, and the fact that "'scientific reasoning' has long been used to justify [their] racial humiliation."[44] Even more impactful than this, however, is the stigma that shrouds mental illness in the black community, and how those feelings of shame function in treatment in white mental health facilities.

Williams points out that black people have a lot of pride in how far they've come in American society—while this is immensely positive, it leaves people feeling like they can't 'let it all hang out,' or look crazy, especially around white people—which has a massive impact on the way that they view and interact with white mental health facilities. Williams recounts an experience in which a young black woman forgets that she has a therapy appointment with a white doctor and goes to the gym, not leaving time to wash and style her hair. Instead of going to the appointment with un-styled hair, she cancels the appointment so as not to give her white therapist the impression that she is not put together. Williams comments: "our deep and insistent need to keep it together, even at the cost of our mental health, is a price worth paying for many of us."[45] Williams' work illustrates how people of color's historical memory, experiences with racism, and cultural nuances affect how they experience mental illness. While so many of the experiences black folks have with mental health treatment and therapy involves interactions with primarily white people, the racism that has pervaded their entire lives affects the way that black people develop and view their own mental illnesses—in a way that is not addressed in the predominantly white spaces of mental health treatment.

From whichever angle we look at it—schools or foster care, under- or over-medication—treatments for mental health and learning disorders are not designed for and are not conducive to people of color, their experiences and trauma, their healing processes, and their academic success. Though prescription is designed and framed as a way to help people cope with disorders, it is being utilized by the school and foster care systems as a way to push students out of schools and make them less of a problem. The clear utter lack of support for students of color and their needs both in public schools and the foster care system illustrates how these institutions were designed with white students in mind—and the systems have not found a way to adapt and support students of color, especially in the era of medicalization.

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[44] Terrie Williams. *Black Pain: It Just Looks Like We're Not Hurting : Real Talk for When There's Nowhere to Go but Up.* (New York: Scribner, 2009), 243.

[45] Ibid, 247.

These two institutions have contrasting assumptions about and approaches to the treatment of youth of color, but both are clearly destructive in their own ways. Moving forward in research and activism surrounding the school-to-prison pipeline, learning disabilities and barriers, and mental health, we need to look at the way that medication is used either as a quick-fix solution or a comprehensive one. This comes down to the motive behind the treatment and the way that we hold and care for our country's youth—people who are "othered" just by holding the status of a minor.

Due to the multi-faceted nature of this issue, it is important to note that this is largely a systemic issue and no single party is solely responsible. That being said, there are individual actors who can play a role in the dialogue and consideration of these issues both in practice and policy. Instead of considering the school's interests—including test scores, funding, and the upholding of the white social norm—the decision to diagnose and prescribe medication to students must be about the child's long-term well-being, with the intention to direct that child into the college-to-cradle pipeline. To do this, the assumptions that are consistently made by school administrators, teachers, public mental health officials, and parents—about students of color and their intellectual and emotional capabilities and needs—must be reconsidered. In doing so, they illustrate their interest and care for children of color in this country and provide a more attainable path to the college-to-cradle pipeline.

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