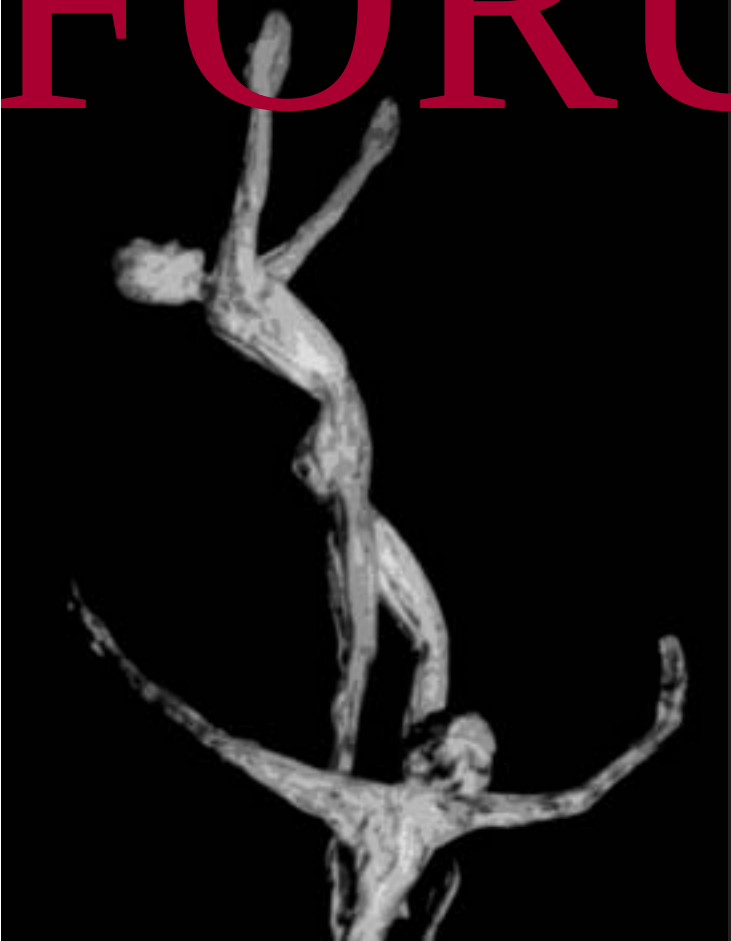
A publication by students of the School of Social Service Administration at The University of Chicago

Advocates' FORUM



2002

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ESSAYS AND ARTICLES

CLINICAL FEATURE

POLICY AND ADVOCACY FEATURES

ON THE COVER

GROWTH by C. Marks
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MISSION STATEMENT

Advocates' Forum explores the clinical implications, social issues, and public policies that are inextricably linked to the social work profession. The journal provides an opportunity to share resources, salient information, and current research that examine the challenges, advances, and innovations of social work. The editorial board seeks to stimulate discussion and debate on relevant issues of the field by cultivating the unique contributions of social work students.

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ONE OF THE HALLMARKS OF THE SOCIAL WORK PROFESSION IS ITS RESPONSIVENESS TO CHANGE. Advocating for change, adapting programs to meet changing needs, and creating new methods of working with clients are some of the ways that demonstrate social workers' keen ability to be closely attuned to life's ever-evolving context.

The past year has been one of much change, ranging from the sobering events that occurred on September 11, 2001 that impact us on a global level, to funding changes for many social service organizations which impact us more closely at home. If dissecting social history has taught us anything, it is that life, as we know it, moves in cycles, that things ebb and flow, and that the world is connected in an intricate dependent web. The nation is moving into a new relationship with the world. Social work is moving into a new era, both exciting and tumultuous. The demand for social welfare programs and perspectives is possibly greater than it has been in decades, yet threats to social welfare funding loom.

As students on the crest of a new millennium in social policy and human relations we felt the urgency of utilizing such resources as this publication to voice our perspective, our idealism and our aspirations for the future of this field. We feel that this journal truly is a forum for advocacy and provides a tremendous opportunity for the students of SSA to have a voice and make an impact. It is with pleasure that the editorial board introduce the 2002 issue. In striving to be the premiere student-produced academic social work journal, we implemented a revised format to reflect our commitment to an academic orientation and employed new criteria by which submissions were measured. These articles reflect the passion, dedication and interests of the students of SSA. It is our hope that they will pique curiosity, prompt reflection, and provide motivation to be actively involved in the world.

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Gang Mediation: Non-Violent Resolution Within a Culture of Violence

by Georgia Jones

This article distills the experiences of four mediators working with juvenile gangs to suggest a nascent theory of gang mediation. Mediations with the gang population seem to be most successful with the following elements: a positive, established relationship between the gang leader and the mediator; an institutional setting; active persuasion of the gang members to come to the mediation table; respect for all participating individuals, and respect for the gang identity.

Although gangs are a nebulously defined social phenomenon that invariably must be studied and addressed at many levels, the potential of mediating micro-level conflicts among youth gangs has been largely ignored. And although informal mediations are likely prevalent, there exists no handbook or guidelines for individuals such as teachers, social workers, or youth workers to inform mediation practice. Orchestrating a successful mediation requires awareness of the forces that prevent gangs from coming to the mediation table, and of the needs and interests that must be met once there. By analyzing the experience of several gang mediators, I identify these forces, needs, and interests and how some mediators address them to achieve non-violent outcomes.[1]

There seem to be two factors necessary to convince gangs to participate in mediation: a positive and established relationship with the potential mediator and a formalized setting, whether that be an institution or a community agency. In order for the mediation to coalesce, the mediator must actively pursue the participants and must claim a stake in a nonviolent resolution. There are two common catalysts of gang conflict: the need to gain personal respect and the need to assert membership in the gang as a form of asserting personal identity. If mediators understand these needs, often the mediation process itself can be structured to fulfill them, thus diverting a violent confrontation.

Relationship with the Mediator

One gang mediator from the New Mexico Center for Dispute Resolution emphasized that, "If we had not had the relationships [with the gang members] built—that was key—we couldn't have gotten them to the table" (Elizalde, Nov. 24, 1998). Another mediator in Chicago said, "The biggest reason why we're so effective is because we have a relationship with the kids…They wouldn't want to sit down to talk if that relationship wasn't there" (Hughes, Nov. 24, 1998). In contrast to mediation with political or business groups, it is almost essential that the mediator have a very personal relationship with gang members in order to suggest mediation as an option.

The importance of a personal relationship lies in gangs' disenfranchisement. Schools, police, politicians, and the media, see gangs as violent, deviant outgrowths that must be stifled. School administrators refuse to recognize gangs as legitimate groups (Elizalde, Nov. 24, 1998). Police routinely stop, question, and search gang youths for no reason other than their gang affiliation (Spergel, 1995). A youth center in a community with gangs went so far as to specifically deny the use of its facilities to gang members because "'they are all just troublemakers'" (Horowitz, 1987, p. 447). This focus on the delinquency of gang members only enhances the rift between mainstream society and gangs.

Gang members acutely feel mainstream institutions' hostility. During one mediation among three gangs, each insisted that the school administration favored the others while disproportionately punishing their own members (Anderson, Nov. 23, 1998). Members complain that police treat them with undue hostility and mistrust (Carstarphen and Shapiro, 1997). This constant bombardment serves only to strengthen gang unity, as members fortify themselves against negative outside opinions and threats (Spergel, 1995; Carstarphen and Shapiro, 1997). With myriad dynamics working to create walls of "hostility, mistrust, misunderstandings and stereotypes" between gangs and outsiders (Carstarphen and Shapiro, 1997, p. 185), any outside interference is suspect.

Mediation is a direct and immediate interference. It is therefore crucial that mediators first prove their trustworthiness. The mediators I spoke with did this in a number of ways. One mediator was a former gang member himself (Hughes, Nov. 24, 1998), and one had "lived a life similar to many of the gang members'"(Elizalde, Nov. 24, 1998). Another specifically kept the school officials out of the mediation, thereby disaffiliating herself from what was perceived as a hostile administration (Elizalde, Nov. 24, 1998). Another offered to

co-facilitate the mediations with a trusted adult of the gang members' choice, thereby building in checks and balances to the mediation process (Michnal, Nov. 25, 1998). Many of the mediators had worked with gang members in different roles, such as social worker or school counselor. These mediators had built positive relationships with youths by advocating for them to the school administration and probation officers (Anderson, Nov. 23, 1998; Elizalde, Nov. 24, 1998), and by devoting additional time and effort, often unpaid, getting to know and understand individual gang members (Elizalde, Nov. 24, 1998). It is virtually impossible to suggest mediation without having established such a trusting, positive relationship beforehand.

Institutional Setting

Most mediations begin with one party seeking outside intervention (Forester, 1994). Because gang culture values violence as opposed to mediation in resolving conflicts, the impetus for mediation must come from outside forces.[2] For most gangs, "fighting is a major and necessary activity…and a means of acquiring respect, admiration, and prestige" (Short and Strodtbeck, 1968, p. 247). The leaders of gangs tend to be those most physically intimidating (Anderson, Nov. 24, 1998), and some gangs will accept new members only if they subject themselves to a group attack by current members (Jankowski, 1991). Violence "serves…the development and maintenance of the 'gang subculture'" (Spergel, 1995, p. 98). It also is integral to protecting the gang from external threats, such as rival gangs or the police (Short and Strodtbeck, 1968). Because violence is often "the only means available" to sustain the viability of the gang (Spergel, 1995, p. 97), it has become institutionalized as a skill and process. Logically, gangs turn to violence, or the threat of violence to solve disputes.[3]

Mainstream culture, however, does not value violence in the same way. Institutions such as schools, the police, and community agencies explicitly discourage it. In virtually all of the mediation cases I studied, there was the threat of punishment by one of these institutions if the conflict ended violently.

The mediators I interviewed understood this threat. In order to induce mediation, they took advantage of kids' physical presence in institutions that would clearly punish fighting. Many mediations took place in schools.[4] One mediator offered a pizza lunch to persuade kids to mediate their conflicts during their normal school lunch hour (Elizalde, Nov. 24, 1998). Another got the permission of teachers to pull kids from their classes in order to attend a mediation (Anderson, Nov. 23, 1998; Michnal, Nov. 25, 1998). It might have been more difficult to gather representatives of feuding gangs in one place outside of the school setting because of lack of transportation as well as question-

able commitment to the mediation process. The school provided a "neutral territory" in which mediation was a possibility (Anderson, Nov. 23, 1998). Although one mediator offered his home phone number to all of the kids he worked with and encouraged them to call if they needed intervention, it was much easier to intervene while they were within the confines of the community center where he worked (Hughes, Nov. 24, 1998). It was a safe, supportive setting apart from the rest of the kids' gang and outside of the gang territory that might be the center of the conflict.

GETTING GANGS TO THE TABLE: MEDIATOR ACTIVISM

Most kids, despite pro-violence gang culture, do not want to fight (Hughes, Nov. 24, 1998; Elizalde, Nov. 24, 1998). If given a choice that allows them to save face and avoid violence, they will take it. Gang influence, however, is strong. If the leaders of these gangs had not approved the mediation program (Anderson, Nov. 23, 1998), invariably it would have been neglected. Choosing mediation is inherently stating that one is willing to try an alternative to violence or, in other words, an alternative to the gang ethic.[5] Directly stating the goal as a nonviolent solution would mean risking alienation from the group, and also would leave gang members without an alternative to mediation if no agreement were reached. They needed to maintain that they were willing to fight, should the need arise. In order to overcome this, the mediators did two things: they actively argued against the kids' alternative to mediation—violence; and they gave kids "excuses" to enter mediation, making it unnecessary for the kids to directly say they were looking for a nonviolent solution.

Some mediators claim that part of activist mediation is "to push [parties] to consider their best alternatives to a negotiated agreement…and the ways of improving [them]" (Forester, 1994, p. 327). In doing this, mediators ask questions, offer different perspectives, and explore both the advantages and disadvantages of opting out of mediation. The intent is not to lead the parties toward or away from mediation, only to help them clarify their options. The gang mediators I spoke with also spent much time exploring the options. There was, however, a consistent focus on what the kids would lose, rather than gain, through fighting. Though mediation was never mandatory (Anderson, Nov. 23, 1998; Hughes, Nov. 24, 1998; Elizalde, Nov. 24, 1998; Michnal, Nov. 25, 1998), the mediators made no attempt to conceal that, in their view, mediation was the superior choice.

In addition to arguing against the kids' best alternative to mediation, the

mediators gave gang members reasons to enter mediation that were not in direct conflict with the gang ethic of toughness. By mediating because of these reasons, gang members could save face and maintain that they would actually prefer to fight, if they were not being "pushed" into mediation.[6]

Mediators use a variety of methods to create these excuses. One called upon her personal relationship with some of the gang members involved. She reminded them of times she had kept them out of jail by advocating for them and asked them to do her a favor by trying mediation instead of turning to violence (Elizalde, Nov. 24, 1998). Another mediator emphasized that mediation was the best option because he "cared about [the gang members]" (Hughes, Nov. 24, 1998). He asserted that he was only looking out for their best interest and took an almost paternal role in addition to mediator (Hughes, Nov. 24, 1998). By framing the push for nonviolence as the mediator's personal mission, gang members can say, if they need to, that it was someone else's idea, not their own.

Institutional rules and incentives also provide an outside push toward mediation. One school program framed the mediation as an attempt to help the gang members "get the most out of their education" (Anderson, Nov. 23, 1998). No doubt this was the goal, however, it was also a way to begin the process of discussing non-violent alternatives to conflict without saying that explicitly. By suggesting mediation as an alternative to probation or jail (Elizalde, Nov. 24, 1998), mediators give kids a legitimate (by gang culture standards) reason to avoid violence. One mediator pointed out that if the kids chose to fight, the police would be involved, which would threaten the gang's drug dealing (Hughes, Nov. 24, 1998). When the outside incentives are already there, mediators need only present the mediation in those terms in order to create a safer space for kids to discuss nonviolence.

WITHIN THE MEDIATION

In some ways, mediation itself is the successful outcome. The goal of every gang mediator is, most simply, to avoid a violent resolution of whatever the conflict may be. The only outcomes that could be considered failures are when gangs do not agree to attempt mediation, or when they decide to fight, regardless of entering the mediation process. For the interviewed mediators, the latter has rarely been the case. Some mediations ended with the conflict "squashed," simply resolved with no further action needed (Hughes, Nov. 24, 1998). Others resulted in "no strike first agreements" where each gang conceded not to start fights, but reserved the right to fight back (Elizalde, Nov. 24, 1998; Anderson, Nov. 23, 1998; Michnal, Nov. 25, 1998). When I asked whether

there had ever been a time when the mediation did not end in some nonviolent agreement, each mediator answered, "No." Why would gang mediation seem to be so successful? In short, "it [is] the mediation process, rather than the product, that [is] most important to the gang members" (Sanchez and Anderson, 1990, p. 55).

To understand why this process can be so effective, one must first understand the roots of many gang conflicts—the need for respect and the importance of the gang identity. Conflicts often stem from the gang members' need for respect and attention. If mediations are conducted to explicitly give these to the gang members, then the mediation itself has fulfilled those needs, and the conflict dissolves. Most gang members strengthen their own gang identity by labeling opposing gang members as the enemy. It is this antagonistic relationship that underlies conflict, not the content of the conflict itself. Mediation is inherently a relational process, and if mediators use this context to redefine relationships, violence becomes a less appealing resolution.

Respect

Virtually all of the disputes mediated by my interviewees involved some show of disrespect. One originated when a gang member was "jumped" by another gang and sought revenge by targeting one of the offending members (Hughes, Nov. 24, 1998). Another involved an interchange of racial slurs (Elizalde, Nov. 24, 1998). Still another began with members of one gang "mad-dogging" members of another, with this insult returned until tensions escalated to dangerous levels (Anderson, Nov. 23, 1998).[7] Any action has the potential to result in conflict if it is interpreted as disrespectful. As Horowitz (1987) explains, "While it may be the intent of the initiator of a challenge to demean the other (requiring an immediate response of violence), …it is also possible that the individual who is insulted may view the actions of the initiator as the result of poor manners and as unintentional" (p. 441). A certain look or gesture could result in injury because it is the *felt* disrespect, not the action itself, that leads to conflict.

The apparently extreme reactions to minor slights are explained by the central importance of respect within gang culture. "The need for recognition, reputation, or status is the common denominator in why individuals, whether or not personally troubled or socially disadvantaged, participate in gangs" (Spergel, 1995, p. 98). Kids gain respect from other gang members and within the gang hierarchy. There are intricate rules as to what actions are disrespectful and what are the appropriate responses (which invariably include some display of toughness) (Horowitz, 1987). The extreme importance of respect is heightened because of the gang's status as an illegitimate group. On the one

hand, gang members use this delinquent reputation as a status symbol within the gang: Who can be the worst, who can commit the most crimes? But on the other hand, society's disdain is keenly felt. For example, "a counselor expelled Jesus, [a gang member], from high school on his sixteenth birthday for extended absences. Jesus called his mother and told her about his situation. The counselor, overhearing the conversation, laughed at him and Jesus punched him. Jesus could have ignored the laugh, defining the counselor as ignorant, but it told him that the counselor had no respect for him" (Horowitz, 1987, p. 447-448). Gang members value the respect of outsiders and are (justifiably) insulted when they infer disrespect.

When mediators understand that the need for respect is often the parties' interest in initiating conflict, there is room to provide this directly through the mediation process. If the mediation is organized through an institution, sometimes the outsider attention is powerful in and of itself. In fact, because these institutions are typically hostile, the attention and acknowledgement implied by recognized mediations within their confines directly contribute to the mediation's success. For example, the administration of Washington Middle School began a series of gang mediations, which most of the student body viewed as special. The mediators provided, "name tags, name plates, folders, pencils, pitchers of water, and cups…in an attempt to create an aura of a serious and important meeting" (Sanchez and Anderson, 1990, p. 55). Violent conflict ceased for the duration of the mediations, before any agreement had been reached (Anderson, Nov. 23, 1998). The respect accorded the gang members simply by being involved in such a grown-up and serious mediation replaced the respect they had had to literally fight for among themselves.[8]

Some gang members indicated that the mediation process was "the first time in their lives that anyone had ever cared about them" (Elizalde, Nov. 24, 1998). In addition to gaining respect from outsiders, the mediation context can be used as an alternate method by which gangs may compete with one another to prove their superiority. One participant described the gang members as "righteous" in their belief that they had been faulted in some way and anxious to prove this at the mediation (Anderson, Nov. 23, 1998). Violence ceased as they had this alternate system for gaining status.

The mediation process can also be used to elicit mutual respect between gangs, even if neither side is forced to admit this. For example, each gang mediator I interviewed created a ground rule of listening respectfully to each participant. In essence, the gang members were forced to show respect to one another because of these involuntarily imposed parameters, rather than offering this respect independently. Despite the outside origin of the respect, the experience of being heard by the opposing gang was powerful. In fact, one

mediation addressing a conflict that had raged for over a year reached a peace agreement in under an hour (Elizalde, Nov. 24, 1998). The mediator simply allowed each gang to tell its side of the story in a safe, neutral environment. This simple act of respect was all that was needed.

Gang Identity

Mediators must also understand the nature of the relationship between opposing gang members. Gang identity is intensely important. Gangs are often "the only 'game' in town for youths to achieve some form of social identity" (Spergel, 1995, p. 100). Gangs are seen as "family" (Elizalde, Nov. 24, 1998), and members are proud to display their affiliation (Anderson, Nov. 23, 1998). Because the gang identity is so primary to members' sense of self, declaring their gang as the best, the fiercest, the most successful is personally reinforcing. "In the process of developing a distinctive social identity, gang members…seek out and initiate challenges to an [opposing gang member's] honor as one way of publicly asserting their claim to precedence and enhancing their reputation" (Horowitz, 1987, p. 441). Challenges to opposing gang members are initiated purely because the target is of a rival gang. Conflicts originate because members of opposing gangs relate to one another in this way—as symbols of the enemy, rather than as individuals.

The mediators I interviewed were familiar with this phenomenon. In one school, kids consistently jumped and attacked members of an opposing gang. They described these fights as against the "Juaritos" (an opposing gang), rather than against "Jose" or "Mauricio"(Elizalde, Nov. 24, 1998). In a different case where two gangs were exchanging racial slurs, the mediator asked one group to identify which kids were involved in the conflict so as to invite them to the mediation. They responded, "They all look alike," revealing that the conflict was against the group as a whole, rather than any one individual (Elizalde, Nov. 24, 1998).

Many mediators work from the assumption that if the kids could simply get to know one another outside of their gang identity, conflicts between at least those two kids would cease (Hughes, Nov. 24, 1998). Mediators use specific techniques to enhance this effect. One ordered pizza for the entire group before the mediations actually began. As she described it, "asking someone to pass you a napkin makes it a little more difficult later on to hate that person" (Elizalde, Nov. 24, 1998). During a gang summit, facilitators used workshops composed of youth from a variety of gangs to emphasize the similarities among all gang members. Each member told about her experiences, and at the end of the workshop, participants were more likely to sit with and talk to one another

socially than they had been prior to sharing stories (Dudley, Dec. 4, 1998). Another mediator emphasized that separating individual gang members from their respective gangs and addressing conflict one-on-one was effective (Hughes, Nov. 24, 1998). The mediator would then play up the kids' similarities, to make them see that they were "two peas in the same pod" (Hughes, Nov. 24, 1998). He focused on their common goals (playing basketball), their common background (from the same neighborhood), and their common predicament (fighting over drug turf that neither one of them was profiting from) (Hughes, Nov. 24, 1998). By personalizing gang members, the hostility originating solely from their different gang identities became much less potent.

This familiarity with the opponent actually prevents future conflicts in and of itself, and this is an important difference between gang mediation and mediations with many other groups. The underlying catalysts of gang conflict are often the need to gain respect and the identification of opposing gang members solely as the enemy. Once mediators understand this, the impact of relationship building and respect within the mediation process itself is huge. Although there are obviously no guarantees of a peaceful agreement, simply getting gang members to the mediating table is a prodigious step.

CONCLUSION

Although gangs are complex and difficult to study, even basic understanding of some common elements can enhance the potential of mediation as an alternative to violence. Gangs are disenfranchised groups and are thus suspicious of outside intervention into their affairs. Intervention often implies punishment or infiltration with the intent to disband the gang. Mediators, as outsiders, must therefore prove their trustworthiness before even suggesting mediation. In addition, mediation within an institution and with external incentives is more likely to happen than if a mediator simply walked into gang turf and offered to solve the gang's problem.

Gang culture has an inherent aversion to mediation in that violence is valued. Nonviolent alternatives are counter to this culture, and those who seek alternatives risk alienation from the group. Many gang members, however, do want alternatives and thus appreciate when mediators take an active role in initiating mediation. Mediators do this specifically by arguing against the violent alternatives and offering gang members legitimate excuses to try mediation.

Once they convince gang members to enter the process, mediators must understand the intense need for respect and loyalty to the gang identity. By showing respect through the mediation process and by creating opportunities for gang members to get to know one another outside the gang context, a non-

violent solution is much more likely.

With these factors in mind, gang mediation programs must continue to be centered in institutions such as schools and community centers. Mediation skills must also be taught to those who work with gang members in other contexts, such as social workers, counselors, teachers, and community members. If the needs of gang members and the functions of the gang were better understood, mediation could be used to successfully replace violent confrontation in many cases. ■

FOOTNOTES

[1] Although this outline is based on in-depth interviews with only a few mediators and is not intended to suggest a theory of gang mediation, it may serve to enhance the knowledge base from which theory is born.

[2] Outside forces are, of course, not the only reason gangs consent to mediation. I am not saying that gang members are personally opposed to mediation (I will address this further in the article). However, it would be difficult to attempt mediation *solely* within the context of the gangs themselves, because this would directly conflict with the positive valuation of violence.

[3] It is important to note that many gang conflicts do not end in violence. Violence remains, however, a first inclination to any threatening or uncomfortable situation, and it is the gang culture's validation of this response that is important to this discussion.

[4] Despite schools' hostility toward gangs, many mediators had professional connections with school administrations which they exploited to obtain permission to mediate. Though this permission was in many cases hesitant and not without reservations and restrictions, schools were sometimes willing to host mediations in the hope of reducing violence.

[5] It is important to note that the gangs in one area were not averse to mediation but instead occasionally sought mediation directly (Hughes, Nov. 24, 1998). It is equally important to note that it was the *leaders* of these particular gangs who approved of and sought mediation, specifically to avoid police intervention if a fight were to ensue. The power of the gang culture over individual members was still very much present, and had the leaders decided that mediation was an undesirable option, individual members would most likely cease using it.

[6] Most likely, they are retaining the option of fighting, rather than this being pure rhetoric. Not one mediator I interviewed, however, had ever mediated where the gangs then decided *to* fight. This leads me to believe that keeping the alternative to fight is more a psychological buffer than a preferable option.

[7] Staring menacingly.

[8] Interestingly, many school administrators view gang mediation with disdain because they recognize that in some way, setting up special meetings during school hours and with school resources implies recognition of gangs as viable groups (Anderson, Nov. 23, 1998; Elizalde, Nov. 24, 1998). It is this form of respect that administrators wish to withhold. It is also this form of respect that can reduce violence especially among middle school-aged gang members.

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Academic Emergency Departments: Mending the Holes in the United States Health Care Safety Net

by Teri Lynn Hinds

As managed care and increasing health care costs continue to squeeze hospitals' bottom lines, the institutions charged with maintaining the safety net of our health care industry are beginning to show signs of wear. Nonfunded mandates, an increase in the number of uninsured, and crowded emergency rooms are only part of the problem facing our nation's emergency departments as they struggle to find balance between costs and quality of care. While additional funding may be one answer, an argument for improved delivery of social services is also presented.

The biggest problem facing emergency departments (EDs) today is finding that delicate balance point between the multitude of forces pulling in all directions. If balance is not found, those forces, including managed care, the rise in the number of uninsured, governmental mandates, and overcrowding of EDs, have the potential to pull apart the safety net of the American health care system. A review of the literature and a May 22nd, 2001, interview with Michael Koetting, Vice President for Planning, Hospitals and Health Systems at the University of Chicago Hospitals, show that the biggest issue of balance appears to occur between the cost of providing emergency care and the quality of emergency and social service care delivered in the ED.

Balance issues exist for all EDs in the country, however, they are especially prominent in academic EDs, which are emergency departments attached to teaching hospitals. This is due to the disproportionately large number of uninsured persons served by academic EDs (M. Koetting, personal communication, May 22, 2001 [Koetting, 2001]; Derlet and Richards, 2000b; Cetta et al., 2000). Academic EDs also are charged with teaching future doctors, which adds to the average treatment time per patient, exacerbating both quality and cost issues (Koetting, 2001). As a result of the ever-present nature of emergencies, there do not appear to be major differences between the Chicago market

and the rest of the country, therefore much of my research and discussion will be generalized from national studies and samples.

COST ISSUES IN THE ED

It is no secret that the ED is a "loss leader" in the medical field (Koetting, 2001; Henry, 2001). The ED is the only medical sector federally mandated to provide service to anyone presenting with an emergency condition (Cetta et al., 2000). Hospitals are required under the Emergency Medical Treatment and Active Labor Act (EMTALA) to provide care to anyone regardless of insurance status or ability to pay (Derlet and Richards, 2000b). Any specialty available in the hospital must also be available in the ED (Johnson, Taylor, and Lev, 2001). On-call lists must be maintained by the hospital, however doctors are not required to participate in on-call lists (Johnson et al., 2001). This creates an unsteady and uneasy alliance between doctors and hospitals to provide mandated care.

The EMTALA is unfunded; neither hospitals nor doctors are reimbursed for the services they provide unless the patient is insured (Carpenter, 2001; Johnson et al., 2001). Even then, in the era of cost containment, many insurance companies, including government sponsored insurance programs, are tightening reimbursement levels for emergency care. As the baby boomers age, Medicare patients make up larger and larger portions of people presenting to EDs (Carpenter, 2001; Reeder et al., 2001). Medical technology has led to people living longer, but they are often more frail in old age and need increased emergency care (Derlet and Richards, 2000b). Pharmaceutical advances have led to more medical management, which means people are not in hospitals already when crises occur (Derlet and Richards, 2000b). Medicare has lowered the reimbursement rate for Medicare-dependent hospitals and for graduate medical education, leaving academic hospitals reeling from a double blow (HHS, 1997; HHS, 2000; Oliver, Grover, and Lee, 2001; Cetta et al., 2000; Koetting, 2001).

Additionally, the insured portion of the population is declining. Changes in welfare have led to fewer adults being enrolled in Medicaid (Ellis, Smith and Rousseau, 2000; Eberhardt et al., 2001; Koetting, 2001). Enrollment has rebounded somewhat since 1998 lows; however numbers are still below or at 1996 highs (Ellis, Smith and Rousseau, 2000; Eberhardt et al., 2001). The cost of health insurance has left many middle-income Americans unable to afford premiums, and employers are not required to offer employer-based health insurance in many areas. The uninsured are likely to use the ED for primary care services because they are unable to pay for services elsewhere.

The idea of increased nonemergency visits by uninsured populations in the face of declining health care coverage is the current favorite among economists and administrators (Koetting, 2001; Viccellio, 2001), however, it does not take into account many truths about EDs. EDs must be prepared for any situation, and, therefore, have telemetry units and monitors at every bed (Derlet, Richards, and Kravitz, 2001). The costs of maintaining such a high level of technology is often cited as a reason that treatment in an ED is more expensive than treatment by primary care physicians (PCPs) for nonemergent patients. However, one must consider that the technology must be there even if EDs eliminated nonemergent patients from treatment. The costs are sunk, which makes the marginal cost of treating patients in the ED no more than treatment by PCPs (Koetting, 2001; Prochazka, 1998). EDs are mandated to be staffed and operational 24 hours a day, 365 days a year. If there are not "enough" emergencies to utilize those resources during all their operating time, the average cost of treating emergent patients will increase because they will have to factor in dead-weight loss time. There is also a social welfare loss if medical resources are available in EDs but not utilized.

The profitability of available inpatient hospital beds is also a concern for ED doctors and staff (Derlet and Richards, 2000b). Many ED patients do not have insurance, and there is an incentive not to admit uninsured patients to the hospital. (Koetting, 2001; Sox et al., 1998). Insurance status has been shown to correlate with admission, even when controlling for severity of illness (Sox et al., 1998). Uninsured patients often cannot afford to pay for the care they receive out-of-pocket. Admitting an uninsured patient takes up a bed that could conceivably be used for an insured patient that would make money for the hospital (Koetting, 2001).

Some have raised concerns that by not admitting uninsured patients, their health status is adversely affected. There is some question about whether the decision not to admit an uninsured patient is based solely on the hospital's finances (Asplin et al., 2001). Patients may work out arrangements with doctors not to be admitted because they do not want to have to be faced with excessive debt (Sox et al., 1998). Uninsured patients may have other limiting circumstances, such as the inability to take time off work, which would further strain their finances if they were admitted (Cetta et al., 2000). A simple correlation does not prove that the decision not to admit is wrong; hospitals could be over admitting insured marginal patients as a profit maximizing technique (Sox et al., 1998). If an insured patient is not likely to require expensive interventions for a high paying DRG, a hospital may choose to admit that patient to recoup some of the "loss" of more expensive patients.[1]

TOO MANY PATIENTS, TOO LITTLE CARE

Complicating cost issues is an increase in demand for emergency services that is resulting in overcrowded EDs. As in the late 1980s and early 1990s, hospital overcrowding is again becoming a national concern (Derlet and Richards, 2000b; Derlet et al., 2001). The causes of overcrowding are varied. Not only is the number of patients seeking emergency care increasing, medical technology and an increasingly litigious society have led to longer work up times (Derlet and Richards, 2000b), which require doctors to spend more time with each patient.

As managed care takes over as the predominant instrument for health insurance, both public and private, more and more people are presenting to the ED with nonemergent conditions as a result of lack of access. Many patients complain that they are unable to get appointments with their primary care physicians on a timely basis (Derlet and Richards, 2000b). This means that people delay seeking care, so when they do finally seek care, they are sicker. People learn not to work within the system, knowing they can simply report to the ED and be seen within a few hours.

Managed care has also placed pressures on hospitals to reduce overhead costs. In many cases, this leaves hospitals without adequate reserves, since they have been forced to cut staff as close to expected or predicted utilization as possible in order to contain costs. Patients that need to be admitted often have to wait hours or days in the ED before an inpatient bed is available (Henry, 2001). Nursing staff is especially affected by this practice since they are expected to maintain both their ED cases and the "admitted" cases that are on the ED ward (Derlet and Richards, 2000b). In order to avoid admitting patients in overcrowded EDs due to unavailability of beds or lack of insurance coverage, doctors are treating and releasing borderline patients that previously would have been admitted (Derlet and Richards, 2000b). Further complicating this issue, more and more patients are relying on EDs for their primary care or are foregoing primary care and reporting to the ED when their condition is worse (Conn et al., 1999).

Savvy hospital administrators have taken to using the ED as "flex" space instead of increasing the size or capacity of an Intensive Care Unit (Zwemer, 2000). Hospitals are placing inpatients in the ED to take advantage of the equipment investment there (Derlet et al., 2001). Obviously, this reduces the number of beds available to ED patients and reduces the ability of the ED to respond to emergencies. While many hospitals have now established observation wards, these wards are still most often within the physical space of the ED and are staffed by the same doctors and nurses.

Follow up in the ED is also difficult. Patients who are insured are often referred to their PCP for follow up, however they may not make the appointment or be able to get an appointment at a time they are able to attend. ED doctors are required under EMTALA to make adequate provisions for follow up, which means that if they think patients will not or cannot report to their PCP, they must make arrangements to run tests while the patient is in the ED or make arrangements to see patients themselves for follow up, often pro bono (Derlet and Richards, 2000b).

Overcrowding has impacts throughout the ED and changes many of the assumptions about incentives and costs stated earlier. If hospitals are overcrowded with emergent cases, nonemergent cases may be gumming up the works. Although all EDs in theory treat patients in order by severity, if there are more people in the ED needing to be triaged, it will take longer to ascertain which patients need help sooner than others (Krakau and Hassler, 1999; Sarver and Cydulka, 2001; Bhimani et al., 2001). A patient who may simply need to have a small but bleeding injury stitched up may at first present as a more severe case than a patient who is experiencing myocardial infarction. Many physicians have horror stories of horrendous treatment conditions in overcrowded EDs. The health and cost impacts are exacerbated if there are long waits and crowded waiting rooms, causing insured nonemergent patients to leave, effectively taking their business elsewhere, or delaying needed care (Derlet and Richards, 2000a; 2000b).

When hospitals are overcrowded, they are also more likely to go on ambulance bypass (Derlet et al., 2001). Bypass is a situation in which an ED essentially closes to incoming ambulance patients; the ED must still treat patients who walk in, but refuses additional ambulance arrivals. Bypass is an important concept especially in the Chicago market. In Chicago, an ambulance is required to take emergency patients to the nearest hospital, regardless of insurance or patient preferences, unless the patient is considered a Level 1 trauma case, in which case they are brought to the nearest trauma center (Koetting, 2001). If hospitals are over-capacity and do not have the resources to continue taking emergency patients, they go on bypass (Koetting, 2001; Vilke et al., 2001). Ambulances are then routed to the next nearest hospital, and it is not difficult to see that this may overwhelm that hospital as well, causing it to go on bypass. In some extreme cases, entire neighborhoods and cities have been on bypass, leaving ambulances chasing in circles and significantly delaying emergency care to patients (Vilke et al., 2001). While it is clearly illegal for hospitals to turn away uninsured patients under EMTALA, if an ED is full and on bypass, it may reduce the number of uninsured patients in the ED.

Hospitals that fill their EDs with inpatients are more likely to "dump" unwanted patients on other hospitals. Decisions to keep EDs small also open hospitals to criticism. Critics claim both of these practices have been observed in hospitals in Chicago (Koetting, 2001).

STRATEGIES FOR IMPROVEMENT

If there were an easy way to stop and reverse the deterioration of our health safety net, it would undoubtedly have been put in place long before now. The political concerns of modern health care include insurance companies, hospitals, doctors, patients, employers, unions, and a multitude of other players. There is no answer that will please everyone. One thing is certain: whatever is to be done must have broad support or it will not survive the challenges of the other effected groups (Leifer and Scott, 1997).

One option is obvious: money. EMTALA is contentious largely because it leaves up to the hospitals how to pay for emergency, and in many cases primary care for the uninsured. Funding EMTALA would solve some of the problems (Derlet and Richards, 2000a; Carpenter, 2001). Because doctors are not paid by hospitals directly, they are not under the control of the hospital administration. Added to this lack of control is a mandate to maintain what amounts to pro bono on-call lists. Hospitals are subject to fines for noncompliance with EMTALA, that is, if they fail to provide lists of specialists who are on-call to the ED, doctors are subject to fines if they sign up for being on-call and fail to show up when called in (Johnson, 2001). Hospitals often call on doctors' professional ethics to sign up for on-call lists, however, as the need for specialist care in the ED rises, doctors are less and less willing to sign up (Johnson, 2001). Some hospitals and professional groups arrange deals with doctors to provide a stipend or subsidy for working on-call shifts (Johnson, 2001). Doctors' costs are rarely covered by the stipends, and they are seen more as a goodwill gesture than any real financial incentive. Hospitals and professional groups are not reimbursed for the stipends and must juggle their budgets, often taking money away from other emergency resources, to pay doctors. Although a workable compromise in the short term, this solution is unlikely to last in the face of increasing use and decreasing payment for emergency services.

Another monetary option, aimed at a different part of the problem, is to provide additional funds directly to hospitals for capital and service improvements in their EDs and inpatient wards (Derlet and Richards, 2000a). Building new wards to hold inpatients is expensive and, in the current age of managed care, risky. If the average daily census should fall and the ward is left

empty, the hospital will lose money. If additional wards are added, they must also be staffed, costing more money. However, building funding capitol improvements could be combined with mandates or requirements by the Joint Commission that inpatients no longer be housed in the ED. Freeing up beds in the ED would allow more patients to be seen faster, shortening wait times and decreasing the general level of stress and chaos in the ED. Additionally, freeing up beds would decrease the necessity for EDs to go on ambulance bypass, creating a more responsive emergency system for the whole community. Capital improvements to EDs would also help to improve quality and timeliness of service to patients (Derlet and Richards, 2000b).

Service improvements could be aimed primarily at those patients who are nonemergent. Studies show that efforts in EDs to increase enrollment in Medicare, Medicaid, and state CHIP programs have promise for raising the number of insured (Carpenter, 2001; Johnson, 2001; Gordon and Depuie, 2001).[2] Similarly, targeted programs that focus on social service needs of indigent and poor patients may help to reduce nonemergent visits to the ED. One study of heavy users of EDs suggests that although the patients may have legitimate health concerns, those concerns are not the primary reason for their visits to the ED (Malone, 1998). The provision of "almshouse" services, such as sandwiches, a warm place to rest, or even a place where they are recognized as human, may be the driving factor behind recurrent visits to EDs (Malone, 1998). These patients may be better served by referrals to community centers where they can rest or obtain food. Many community centers, however, are seen as degrading and dehumanizing. An indirect option for decreasing ED use by these patients may be to provide better social service options in the community. Addressing just the health and access needs of these patients may not decrease their usage of the ED (Prochazka, 1998), which they identify as a safe and respectable institution (Malone, 1998).

Many of the ED patients in inner-city EDs are also substance abusers, or alcoholics or suffering from mental illness (Chan et al., 2001). Addressing the underlying problem of drug addiction, instead of simply providing a place to detox, may decrease ED usage by these patients (Chan et al., 2001). Quality referral networks must be in place in order to assist such patients; again, this must be addressed as a community problem, not just a hospital or health problem. However, an argument cited against increasing the social services provided ED patients is that the number of patients will increase in response to the services, a version of "if you build it, they will come" (Koetting, 2001; Derlet and Richards, 2000a).

These last two suggestions rely on resources in addition to money: social

service workers. Chicago is a city populated with at least four graduate level social work schools; academic hospitals are almost always paired with universities that have quality clinical social work programs. With a minimum of full- time staff and a commitment to teaching and learning, hospitals could provide quality social service support in their EDs at low cost. Even if the studies prove to be wrong and the conventional wisdom of "if you build it, they will come" right, the net benefit to the community and the students working in the ED cannot be discounted. If academic hospitals are truly as committed to teaching and learning as they pretend, they will be hard pressed to turn away enthusiastic, willing, and able workers from a population much in need of social services.

BALANCING THE SEESAW

Children learn many basic lessons in physics on the playground, but the concept of balance taught by a seesaw is also applicable in policy and business. Rarely is a seesaw held in stasis; it is constantly rocking back and forth as momentum and gravity exert their forces. Unlike a child's seesaw, hospital administrators and politicians at the local, state, and federal level must strive to find a way to make the seesaw stop. Our nation's health care safety net is dangerously close to annihilation, and only by working together to balance the costs and benefits can we expect to right it. This is no easy task, but it is an essential and urgent one. In the words of one doctor, it would indeed be ironic if we were the next ones requiring emergency care from the floor of the a crowded ED. ■

FOOTNOTES

[1]Diagnostic related groups (DRGs) comprise the base for the Medicare prospective payment reimbursement methodology. Many states also base Medicaid reimbursement on DRGs. DRGs allow for the linkage of reimbursement to a patient's diagnosis and a reimbursement level considered appropriate for that diagnosis based on an average base payment adjusted to provider location, wages, and medical education, rather than providing reimbursement for services actually provided.

[2]The State Child Health Insurance Programs (CHIP) were passed in 1997 by the federal legislature as a means to provide health insurance coverage to low income children, and in some cases their families, that has more generous eligibility requirements than traditional Medicaid programs. States were allowed to either create new CHIP programs or to expand their Medicaid programs under CHIP legislation.

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Reflections on Cultural Matching in Direct Practice

by Rose M. Perez, Gabriela Ibarra, and Rafael Leon

The benefit of cultural matching between clients and therapists is a topic that has received little attention in the research literature. In light of recent demographic changes in American society and the increasing diversity of the social work client population, this issue is worth exploring. A group of Latino social work students at the School of Social Service Administration at the University of Chicago decided to explore this issue by interviewing a family with whom they felt they culturally matched. In this article, they describe their experience in interviewing the family and delineate some of the advantages of their being culturally matched. Implications for practice are offered.

The low quantity of research that explores the question of whether or not participants are best served when they are culturally matched with clinicians is inconclusive (Atkinson, 1986). Even if research were to support such a proposition, the chance of it occurring is weak, given the large numbers of diverse participants and the low number of available culturally diverse providers (Atkinson, 1989). The concern over cultural matching is exacerbated when we look at the lack of information from which today's clinicians draw to inform their practice with diverse populations. Notions of human behavior and development that inform today's practice arena have, for the most part, been based on theories developed while studying white, middle class, nuclear families. Awareness of the impact of culture on theories of development has only recently begun to gain attention and challenge older, established notions.

Recent literature now sees culture as deeply entrenched in society (D'Andrade, 2001) and as interactively linked with the psyche (Shweder, 1990), claims that are now pushing the need to revise older, established psychological theories. An example of recent changes can be seen in the growing body of research drawing on the distinction between individualist and collectivist cultures. Collectivist cultures are described as ones in which people define their sense of self as a function of those around them in a contextualized

or interrelated way, whereas in an individualist culture, people tend to place less emphasis on the surrounding context (Markus and Kitayama, 1991). Asian and Latino cultures are often associated with a collectivist orientation and U.S. mainstream culture with an individualist view. Recognizing such a distinction is only elementary, however, considering that the ways in which such norms are actualized affect the day-to-day communication and interactions between people in subtle yet significant ways.

Concern for how diverse participants are being served, combined with growing awareness of the impact of culture on interactions between clients and service providers, sparked the interest of a small, fairly homogeneous group—all bilingual and bicultural immigrants from Latin America—to explore the qualitative aspects surrounding this topic. Our group intuitively felt that recent cultural insights provide only an introduction to understanding the large number of cultural groups represented in American society. The perceived gap in the ability to understand and provide clinical services for today's ever increasing multicultural family led our group to reconsider how the question of the cultural matching of clients and service providers affects a great number of social work participants.

We selected a family with which we were culturally and linguistically matched to conduct a two-hour open-ended clinical interview. The three of us interviewed the Lopez family, a pseudonym, in November, 2001, at the family's home in Chicago.[1] The six-member family comprises four offspring (two adolescents and two young children) and their biological mother and father. This article highlights some of the cultural aspects that emerged from the clinical assessment of this family, reflects on our individual interface issues during this process, and discusses what we feel are some of the implications of cultural matching for direct practice.

CLINICAL ASSESSMENT

Our group believes that our being culturally matched helped this family to quickly and easily connect with us. As we engaged the Lopez family in conversation at the dinner table, our impression was that it seemed to candidly and graciously share its family story with us. As the interview progressed, we attributed our ability to empathize with them to our having had similar life experience to theirs. We feel that it was our empathy that seemed to help the family members feel understood and contributed to the disclosure of information which was, at times, highly sensitive in nature. For example, this family discussed its concerns regarding its immigrant status, offered details about the stress created by the unplanned pregnancy of the youngest child, and divulged

secrets of physical abuse in the mother's family of origin.

The family's comfort with us was apparent throughout our time with it. Whereas many families might feel imposed upon when they are called upon to be the subject of a research study, this family warmly thanked us for choosing it and insisted that we return another day to talk some more. We attribute the success of our interview to our ability to connect in culturally sensitive ways that extend beyond verbal communication. Our being Latino and having had similar life experiences seemed to contribute to the strength of the interaction.

Another area where we felt that our being culturally matched was helpful was in the assessment process. We felt that we were able to understand topics rarely broached in psychology and social work texts, thus helping us to assess the family from a strengths, rather than a deficits, perspective. The familiarity some of us had with Mexican culture helped us to understand and appreciate the couple's enthusiasm as they elaborated at length about their courtship and marriage rituals. This ritual involved symbolic gestures such as formally requesting the bride's hand in marriage while offering a bottle of tequila as a gift to her father. We assessed their discussion of this ritual as culturally appropriate signs of respect among the families of origin and wondered whether someone unfamiliar with this tradition might see the use of alcohol as problematic.

A second way in which our being familiar with its culture was helpful was in the way we assessed the gender roles in the family. The father's domineering manner might all too easily be pejoratively cast as machismo, while the positive aspects of machismo might go unacknowledged. Our consensus was that it was clear that the father's dominating much of the discussion does appear as a sign of a family with a hierarchical power structure. At the same time, we felt that such a family structure seemed to provide clear structure, organization, and direction to all family members.

A third area where we felt our cultural familiarity was beneficial was in the portion of the family's discussion involving witchcraft. The parents shared their belief that a family member had gotten epilepsy as a result of a spell placed on her by a jealous rival. The role of *brujería* (bewitchment) in Latin cultural practices is documented in Latino psychology literature (Falicov, 1998). Our personal knowledge of how it manifests within our culture and our experiences working in clinical settings with Latino clients who have discussed it helped us to quickly and easily normalize this family's story, without needing to read about it.

Assessing this family's functioning was challenging in many ways. If we utilized psychological literature at face value, many of the areas we judged as survival strategies might have been confounded with deficits. First, this family's

organizational structure is rather rigid. Rigidity, in the literature, is typically discussed as serving a negative function in family functioning (Olson, 1993). Yet, in this family, such rigidity seemed to translate to firm boundaries, adherence to rules and limit-setting techniques, and consistency in discipline and expectations that seem to protect members from multiple stressors. The Lopezes cope with scarce economic resources, living space constraints (all four children share a bedroom), mixed immigration status, and more. Mixed immigration status refers to family members differing in their legal status. In this family, the two oldest children and the parents were born in Mexico and, despite being in this country for many years, have not yet been able to gain documented status. Thus, the two oldest children are ineligible for government benefits while the two youngest, born in the U.S., are. It seemed to us that their hierarchical power structure kept such tensions and stressors at bay.

Second, this Latino family's ability to communicate openly about deeply personal feelings and events combined with its overtly expressive loving emotions, might, by North American standards, be seen as possible signs of enmeshment. Mainstream American theorists have discussed enmeshed families as ones in which there is too much closeness and too little autonomy (Nichols and Schwartz, 2001). Yet, autonomy is not a core Latin American value. Our familiarity of Latinos relating in more interdependent as opposed to autonomous ways, along with our ability to understand the cultural codes by which communication typically occurs, helped us to see this family's behavior as being within the normal range.

Third, where family secrets are normally discouraged by therapists, the Lopezes use of family secrets seemed to protect the children from becoming sad and feeling powerless. For example, the children were not told about their uncle's death or their maternal grandmother's illness, both of which took place in Mexico—a place to which the family could not readily return—or about the details of the family's legacy of abuse.

Our motivation in selecting and interviewing this family helps us to draw attention to the clinical aspects of working with such populations. As we lend a voice to the needs of people such as those discussed here, our group has also been affected. This family's narrative induced us to recall both happy and painful personal memories. Our writing about its story helps us to expand our own self-understanding and represents and validates our own life stories.

CLINICAL INTERFACE ISSUES

Our group felt as though there were many similarities between the Lopezes' experiences and those of our own families. The Lopezes' difficulties related to

immigration resonated with our own life histories. All of the members of our group emigrated as children from a Latin American country—two of us from Mexico and one from Cuba. Each experienced similar interludes with the Immigration and Naturalization Service (INS) to gain legal residency and struggled with difficult separations with family in our home countries. Another similarity between the group members and the Lopezes is that in the early period of our immigration our families experienced similar harsh economic limitations. And still, today, our families continue to hold on to many native cultural traditions and norms and live in traditional ethnic enclaves like the Lopez family. Also, like the Lopezes, our families of origin were also patriarchically organized.

Although we shared many cultural similarities with the Lopezes, especially when we were recent immigrants, there are now many economic and social differences between us that need to be acknowledged. First, all of our families attained legal status a long time ago. Perhaps this fact has resulted in significantly different life paths. We have all reaped the benefits associated with U.S. citizenship such as higher education. By contrast, the Lopezes undocumented status prevents them from enjoying such similar rights. In particular, our hearts went out to the undocumented Lopez children who are nearing college age and will most likely not be able to find the means to attain a college education.

Our group feels very fortunate to have been able to benefit from such societal privileges, but access to such privileges has also invited challenges in our ability to adhere to the traditional norms and values of our culture of origin. For example, while all of the members of our group are still in school and live in fully bicultural environments, we took notice of the young ages at which the Lopez family formed and the responsibility that the parents have in raising four children amid such adverse living conditions. Also, while motherhood has an important place in Mexican culture, it is more optional in the U.S. culture to which we have acculturated, leading us to consider this issue as one of the many cultural aspects that each of us has had to navigate in our bicultural quests toward integrated identities. For example, while our group could appreciate the Lopezes' hierarchical norms as protective mechanisms, given our current level of acculturation, we reject much of the associated gender typing that such norms lead to. In particular, some of us resented Mr. Lopez's dominant character, possibly because it reminded us of our own struggles negotiating with parental authority in our quest to integrate into U.S. society.

Having acknowledged differences between our group and the Lopezes, it is also important to discuss some of the differences among our group mem-

bers. Being from similar cultural backgrounds does not necessarily imply that there was consensus in what we observed. We became aware that our differences influenced how we viewed and understood the family. An example of this is when each of us interpreted in different ways a comment that the father made. When the father responded to the question of who constitutes the family, he replied that the family is composed of those in the room rather than others elsewhere—alluded to by pointing both hands over his right shoulder. We did not get an opportunity to probe further, therefore we do not know to whom he was referring as not composing the family. What was intriguing about this brief tale is that the three of us all had a different interpretation of whom he was referring to. One of us flirted with the idea that has been described as existing in some Mexican families involving a "*casa chica* [small house]" where the father's "mistress" lives in addition to the "casa grande [big house]", which houses the legitimate family (Falicov, 1998). Another of us thought Mr. Lopez could have been referring to his own family of origin. A third interviewer thought that Mr. Lopez was talking about his sister-in-law who was sleeping in the other room. Such differences in our individual interpretations help us to realize that, in spite of our shared ethnicity, within group differences also matter.

IMPLICATIONS FOR PRACTICE

Our group felt that recognizing clinical interface issues such as the above-mentioned ones is important to being able to assess the well-being of any family. Not doing so runs risks such as overidentifying with clients. Excessive identification with clients and little introspection on the part of clinicians may render unclear which issues are the real ones being worked out, those of the therapist or those of the client. Psychodynamic theorists discuss the emergence of transference and countertransference phenomena between therapist and client. Originally conceived by Freud (1915-1917/1966), these concepts have been adapted and expanded upon by contemporary theorists. Transference is seen as a pattern of expectation that emerges in the course of development and life experience that is presented as a re-creation and elaboration of these expectations in an effort to preserve the sense of self. These expectations shape interpretation of experience and behavior; one is predisposed to process relational experience in particular ways without the flexibility to consider alternative readings of the situation (Borden, in press). Countertransference, which can potentially serve as a source of information helpful in the intervention process, is viewed as the role-responsive complement of transference, responding to the pushes and pulls of inflexible maladaptive ways of interacting that emerge from

the transference (Borden, in press). In order to be able to utilize these phenomena, therapists must possess a sense of self-awareness gained from having closely examined their own issues. Our being culturally matched in no way excuses us from analyzing how our own subjectivities might enter our work.

We saw many benefits to our being culturally matched with the participants we interviewed and assessed, both from the point of view of participants and from ours. From participants' vantage points, we imagine it facilitates their ability to trust and connect with us in conscious as well as unconscious ways. Experiences with people who can "mirror" us are important for the development of a healthy sense of self (Elson, 1986) and the lack of mirroring for some minority cultures has also been discussed as problematic (Suarez-Orozco, 2000). Our ability to understand their language and its cultural subtleties along with our ability to empathize with their culture in sensitive ways seemed an important component in our encounter.

From our point of view, we felt that our being culturally matched with this family helped us to assess it from a strengths perspective for all of the reasons noted earlier in the clinical assessment. A second area in which we feel it helped us to have first-hand insight into the family's culture was in our group's ability to fill in where gaps in the literature have not satisfactorily provided an answer. In our view, there is very little literature that would have been able to fully prepare us for all that we encountered. We feel that the richness that this body of research warrants is yet to arise. Even if such literature were to exist, our having had first-hand experiences in hearing about such things as witchcraft helped us to normalize the family's experience without blinking an eye.

Our group being bicultural gives us an advantage in being able to discuss the topic of cultural matching. In all of our daily interactions, we come face to face with people who are like us and people who are not like us. In each of our careers, we have pursued paths that keep us close to our culture, and we maintain culturally matched as well non culturally matched relationships with others. In an atmosphere where there are so few Latinos in higher education, there are probably few instances in which researchers are culturally matched when studying Latino populations. We feel fortunate to have been able to work as a team to report on such an issue and feel proud in being able to lend a voice to our own. That we, despite our inexperience, have taken on the tall order of reporting on such an issue that, if nothing else, suggests more work is sorely needed and, given the increasing numbers of culturally-diverse groups, highly warranted!

There are some limitations to the views we express here. First, this account is one-sided and based on a single case analysis. Thus, there is no con-

trol group with which we are comparing our findings. Second, in reporting our implications for practice, it is also possible that our group failed to notice and report on things that might be interesting to non-Latinos. The role that culture plays is very complex, and the nuances range from very subtle to very explicit. Communicating the details of such to anyone from a different culture is never likely to do it justice. Further, although our group sees many advantages to being culturally matched, our group is not advocating cultural matching as an exclusive component of clinical work. Any therapist must be capable and professionally trained and capable of working with many different types of people. Further, there are many other variables (for example, race, class, educational status, sexual orientation, personality) that are as important as culture.

The complexity involved in clinical interactions make it difficult to conduct empirical research on such matters. Culture is, after all, ubiquitous and hard to delineate. Ethnic differences are just a subset of cultural differences. The family we studied faces life daily with multiple stressors including poverty, mixed immigration status and low education. Even though our own group was culturally matched, there were differences of subculture, linguistic nuances, immigration experience and status, acculturation, education, class, phenotype, and conceptions of gender. Thus, isolating the relevant from the irrelevant variables is arduous, to say the least. At the same time, qualitative expressions such as the ones we have uttered serve only to highlight the complexities while leaving our thirst for a response to the question of cultural matching inadequately quenched. ■

FOOTNOTE

[1] Some of the data used to describe the family have been altered to protect confidentiality.

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Sex Offender Treatment Plan

by Emily Michael

This article outlines a sample behavioral treatment plan for an adult male sex offender. Treatment techniques were derived from empirically supported studies that are reviewed throughout the text. The history, evolution and efficacy of sex offender treatment strategies are discussed. Relapse prevention and follow-up strategies are recommended, as is the need for future research.

"Jack" is a 32-year-old man who was recently arrested for molesting a 12-year-old boy.[1] This is his first reported offense. At Jack's arraignment, he was fined for court fees and sentenced to 5 years probation with a minimum of 1 year of mandatory psychological treatment at a community-based sex offender treatment program. As a staff social worker at this sex offender treatment program, I was assigned Jack's case. By the time I first met Jack, he had already been seeing a therapist for 2 months, he had accepted responsibility for this and other unreported offenses, claimed to understand how his actions affect his victims and was ready to commit to a treatment program.

Definition and Goal of Treatment

O'Connell et al. (1990) define a sexual offense as "a criminal offense involving sexual behavior when one party does not give, or is incapable of giving, fully informed consent…[this definition] also includes situations where the difference in power between the two parties is such that one is not in a position to make a truly free choice [i.e. child molestation]" (p. 11). The goal of behavior therapy with sex offenders is not to cure the offender of his deviant sexual fantasies; in fact, it is unlikely that a treatment program could completely reorient a pedophile's arousal pattern to one that is aimed exclusively at consensual sexual activities with adults (Crolley et al., 1998, p. 486; O'Donohue et al., 2000)[2]. Instead, treatment is aimed at lessening the intensity of the offender's deviant fantasies; incorporating new, appropriate fantasies into his repertoire; helping him to identify his negative cognitive-behavioral offense chain; and

developing appropriate coping mechanisms to help him control his responses to deviant fantasies and impulses as they occur (O'Donohue et al., 2000; Stoner and George, 2000; Marshall, 1999).

BEHAVIORAL TREATMENT TECHNIQUES

Before 1970, the treatment of sex offenders was largely psychoanalytic in nature. The growing presence of behavior therapy provided clinicians with an empirically based treatment modality that addressed offenders' problems more comprehensively. However, because deviant sexual behavior has strong cognitive antecedents, cognitive therapy techniques are combined with behavioral interventions in order to achieve the best results (Polizzi et al., 1999; Marshall, 1999). There are several cognitive steps preceding the behavioral portion of most sex offender treatment programs. Offenders are asked to disclose all offenses, analyze thoughts and feelings during perpetration, restructure cognitive distortions and pro-offending attitudes (such as, "she liked it, it did not hurt him, laws do not apply to me"), and explore overall social functioning (Marshall, 1999; Schwartz and Canfield, 1998).

The preceding cognitive techniques occur during the first stages of treatment. Once the offender accepts responsibility for his actions, is able to empathize with his victim(s) and has cultivated significant motivation to change his behavior, the behavioral (and cognitive-behavioral) reshaping techniques are implemented (Aubut et al., 1998). Those most widely discussed in behavior therapy literature include tracking deviant fantasies, impulses, and behaviors; covert sensitization; orgasmic reconditioning; and relapse prevention. They are implemented in different ways, but most of the programs I surveyed include a combination of these techniques into their treatment structures.

Tracking Deviant Fantasies, Impulses and Behaviors

This tracking process (Marshall, 1999; Aubut, et al., 1998) involves listing all fantasies (both appropriate and deviant) that occur during masturbatory and non-masturbatory fantasies and daydreams. The importance of this distinction is twofold. First, sexual fantasies do not occur exclusively during masturbation, therefore it is important to examine whether the content is different in different contexts. Second, because masturbation serves as a reinforcer for fantasies, it is necessary to record the conditions surrounding the occurrence of deviant fantasy in order to effectively implement an intervention. The client then describes any attempts made to resist acting upon the fantasies. If the client was successful in resisting, he describes how he was able to resist. If unsuccessful, he records how he acted upon his fantasy and what he could have done instead.

During therapy, the client is asked to ascribe meaning to his fantasies and explore how they serve to maintain offending tendencies and behaviors.

Covert Sensitization

The goal of covert sensitization (Barlow, 1998, Crolley et al., 1998; Schwartz and Canfield, 1998; O'Connell et al., 1990) is to integrate long-term consequences into the mind of the sex offender. To achieve this goal, strongly arousing sexual fantasies are paired with worst-case scenario consequences (e.g., "imagine you are touching your daughter's breast and your wife and the family priest walk in the room and catch you. They react with horror, your wife faints, your daughter runs out of the room screaming, the priest is speechless...") (Barlow, 1998, p. 458). The therapist dramatically recreates these scenes for the client during several sessions in order to solidify the scenario in the client's imagination. The client is then asked to rehearse the scenario in his head over and over again outside of therapy until he is no longer aroused. This process is then recorded on an arousal chart.

Orgasmic/Arousal Reconditioning

With orgasmic/arousal reconditioning (Barlow, 1998; Crolley et al., 1998; Schwartz & Canfield, 1998; O'Connell et al., 1990), the client is asked to masturbate to deviant sexual fantasies followed by the insertion of an appropriate fantasy just before ejaculation. Eventually, insertion of the appropriate fantasy should begin to occur closer and closer to the beginning of the masturbatory session. Ideally, after much practice, the client should still be able to reach orgasm while masturbating to an appropriate fantasy.

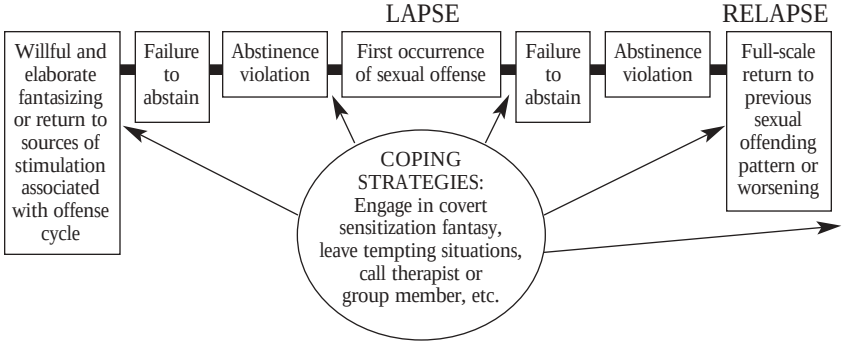
Then, while the client is in a nonaroused state, he is asked to verbalize an inappropriate sexual fantasy for a specific amount of time. If at any point he becomes aroused while verbalizing this fantasy, he is to continue verbalizing until the arousal subsides, thus proving to himself that he is able to control his arousal in the face of his deviant fantasies.

Relapse Prevention

In relapse prevention (Barlow, 1998; Marshall, 1999; Crolley et al.; Schwartz and Canfield, 1998; O'Donohue et al., 2000; Stoner and George, 2000), the offender identifies his victimization cycle and the cognitive-behavioral offense chain within that cycle. For example, if his offenses are against young boys, the offender is asked to explore factors that make him vulnerable to reoffending, such as the use of child pornography, his proximity to children, the use of substances to lower his inhibitions, or a desire for closeness. It is important that

the therapist and client identify a list of coping strategies that the client can use when he is overcome with the impulse to offend. The client's cognitive-behavioral chain is diagramed so that he can see exactly where he needs to implement these coping strategies to keep himself from reoffending or, if he does offend, he knows how to take steps to keep it from happening again. The chain might look something like Figure 1 (Stoner and George, 2000, p. 68):

FIGURE 1



The client is then asked to develop two lists (Figure 2) of warning signs: one consisting of signs that only he can identify, the other of signs that are visible to others (Marshall, 1999). These lists are both kept by the client, and list two is distributed to others with whom he has close contact so that they can intervene if they suspect that warning signs are present.

FIGURE 2

LIST ONE (self-identifiable)	LIST TWO (other-identifiable)
• Return of deviant fantasies	• Excessive time spent with children
• Desire to get drunk	• Being unaccountably alone
• Loneliness	• Social withdrawal
• Etc.	• Etc.

EMPIRICAL FINDINGS

It is extremely difficult to eradicate all traces of deviant sexual fantasies. However, cognitive-behavioral interventions have been shown to reduce or prevent sex offender recidivism. Crolley et al. (1998) conducted a recidivism study with 16 offenders who received cognitive-behavioral therapy at a treatment program in Atlanta. During the post-treatment follow-up period (approxi-

mately 26 months in duration), only one of the 16 clients reoffended and is now in jail. Although single-incidence studies like this cannot be generalized to the entire group of sex offender treatment programs, this data certainly supports the notion that "behavior therapy can be effective in reducing deviant sexual arousal and in enhancing appropriate consensual sexual behavior" (Crolley et al, 1998, p. 1).

In a meta-analysis of 13 sex offender treatment programs, Polizzi et al. (1999) conclude that "cognitive-behavioral treatment programs appear to be effective in reducing recidivism among sex offenders" (Polizzi et al., 1999, p. 364). Specifically, these researchers find that nonprison-based sex offender treatment programs had the best results in reducing deviant sexual arousal and recidivism. Their findings suggest that prison-based programs were less scientifically meritorious; therefore results from many of the prison-based programs carried less weight in the meta-analysis. Perhaps this is an indication that community-based alternatives are more comprehensive and rigorous in their treatment design. Options such as halfway houses, where offenders live together and abide by strict house rules (e.g., curfew, attendance at therapy groups, etc.) may be good solutions for keeping the community safe while also providing effective treatment for sex offenders.

Barlow (1998) cites a study by Maletzky (1991) in which he and his staff report on success rates of about 5,000 sex offenders who received cognitive-behavioral therapy at a sex offender treatment clinic.[3] The data were collected over a period of up to 17 years. Criteria for treatment success in his follow-up were as follows: client completed all treatment sessions, client demonstrated no deviant sexual arousal on plethysmograph testing at any annual follow-up testing session, client reported no deviant arousal at any time since treatment ended, client had no legal record of any charges of deviant sexual activity (pp. 459-60).[4]

The results of Maletzky's research (displayed in table 1) strongly support the efficacy of cognitive-behavioral treatment of sex offenders.

TREATMENT PLAN FOR "JACK"

Problem

Jack is sexually attracted to young boys and has acted on that attraction on more than one occasion. His actions have included fondling boys' genitals and making young boys masturbate him to orgasm. Jack is suffering from the consequences of his actions. His story was published in the local newspaper, he was imprisoned for a short period of time, he lost his job, most of

TABLE 1

DIAGNOSTIC CATEGORY	% SUCCESSFUL AT TIME OF LAST FOLLOW-UP
Heterosexual pedophilia (n=2,865)	94.7
Homosexual pedophilia (n=855)	86.4
Hetero & Homo pedophilia (n=112)	75.7
Other multiple paraphilias (n=54)	71.7
Exhibitionism (n=770)	93.1
Rape (n=145)	73.5

ADDITIONAL DIAGNOSTIC CATEGORIES ARE LISTED BELOW:
Public Masturbation (n=75), 91.1; Voyeurism (n=70), 88.1; Frotteurism (n=60), 80.6; Transvestitism (n=60), 91.7; Fetishism (n=30), 88.8; Obscene telephone callers (n=25), 100; Sadomasochism (n=25, 80; Zoophilia (n=20), 100.

his friends have turned their backs on him and his family is deeply ashamed.

Goal

Jack would like to learn how to control his impulses and lessen their intensity so as not to endanger other children. He wants to begin to rebuild his life.

Assessment Procedures

I will start by administering a battery of tests in order to determine Jack's current state of mind, his current sexual interests, and his level of sexual deviance. First, I will use the Structured Clinical Interview for the DSM-IV (SCID) to complete a diagnostic evaluation with Jack in order to screen for personality and mood disorders. If he tests positive for either or both of these, I will adjust my treatment plan accordingly (i.e., refer him to a psychiatrist for psychopharmacology and implement additional behavioral techniques specific to his comorbid disorder(s)). Next, I will administer the Multiphasic Sexual Inventory II (MSI-II), which is a "self-report questionnaire that consists of various scales addressing sexual knowledge, validity, and sexual deviance" (Crolley et al., 1998, p.489). The MSI-II has been proven to be a reliable measure of sex offender sexual characteristics.

Sexual History

It is important to gather a comprehensive history of Jack's sexual life. I will assess his own sexual abuse history to see if perhaps he was abused or mistreated as a child. I will assess his attraction to both men and women, and

obtain the numbers and types of appropriate sexual encounters he has experienced. I will then examine his deviant sexual history, assess when it started, how many people he has victimized, the circumstances surrounding victimization, and the length of time between offenses. Together, Jack and I will chart this history so that we are both able to refer to his historical patterns throughout treatment.

Fantasy Tracking

In the next part of treatment, I will ask Jack to begin tracking his sexual fantasies, both appropriate and deviant. To facilitate this baseline gathering process, I have designed a Sexual Fantasy Tracking Sheet that he can use to chart his experiences. If it proves to be difficult for him to use, we will make any necessary changes to simplify the structure. Over time, these charts will help us to see Jack's progress in reducing the number and intensity of inappropriate sexual fantasies. When we develop coping strategies for him to use in helping resist deviant impulses, he will start charting those on this sheet as well.

Arousal Reconditioning

The next phase of treatment involves sexual arousal reconditioning techniques including covert sensitization and orgasmic reconditioning. Jack will use covert sensitization by pairing strongly arousing sexual fantasies with worst-case scenario consequences (e.g., "imagine you are being masturbated by a young boy. You are about to reach orgasm when your mother, your boss, and the boy's father enter the room. Your mother screams, your boss leaves in disgust and will tell all of your coworkers what has happened, and the boy's father runs at you with clenched fists..."). I will dramatically recreate this and other scenes for Jack during several of our sessions in order to solidify the scenario in his imagination. I will then ask Jack to repeat the scenario in his head outside of therapy until he no longer achieves an erection from the thought of being masturbated by young boys. This process will then be recorded on an arousal chart.

Jack will also engage in orgasmic reconditioning exercises. I will ask Jack to privately masturbate to deviant sexual fantasies followed by the insertion of an appropriate fantasy just before ejaculation. This will continue until he reports that he is able to have an orgasm that results from an appropriate fantasy (e.g., consensual sex with an adult). Then, I will ask Jack to verbalize one of his inappropriate sexual fantasies for a specific length of time. f at any point he becomes aroused while verbalizing this fantasy, he is to continue verbalizing until the arousal subsides, hopefully proving to himself that he has the ability to become aroused by sexually appropriate fantasies.

Relapse-Prevention

In relapse prevention, Jack will identify his negative behavior cycle and the cognitive-behavioral offense chain within his cycle. We will explore factors that make him vulnerable to reoffending, such as those previously described (e.g., the use of child pornography, his proximity to children, the use of substances to lower his inhibitions, a desire for closeness, etc.). Then we will identify a list of coping strategies that he can use when he is overcome with the impulse to offend. We will explore where these coping mechanisms should be implemented within his cognitive-behavioral chain so that he can clearly identify times in which he needs to take steps to stop his cycle (see Figure 1).

A second part of relapse prevention is the development of lists of warning signs. One will contain signs that only Jack can identify; the other will consist of signs that are visible to others. Jack will keep both of these lists; I will keep list two and also give it to his probation officer and housemates. Throughout the course of treatment, the effectiveness of these interventions will be evidenced in Jack's Fantasy Tracking Sheets, his covert sensitization graphs and the reports of others involved in his treatment and life.

Follow-Up

Once Jack has completed his treatment, I will follow-up with him on a bi-weekly basis for 3 months and then monthly for the following 9 months. We will meet to discuss any problems he has had and whether or not there has been a resurgence of deviant arousal or behavior. Jack will also be assessed using plethysmograph testing to ensure that his self-report is accurate.

CONCLUSION

Just as it is impossible for substance abuse treatment programs to completely remove their clients' cravings for drugs and alcohol, it is also extremely difficult to eradicate all traces of deviant sexual fantasies in sex offenders. All pleasurable-yet-undesirable behavior has high recidivism rates, for obvious reasons. Fortunately, cognitive-behavioral interventions have been shown to reduce or prevent sex offender recidivism. Programs that aim to help sex offenders identify and control their responses to deviant fantasies and impulses and offer alternatives to victimizing behavior continue to achieve new successes with clients. Further research, development and implementation of these effective treatment regimes will continue to help save children from becoming victims of sexual crimes and will assist offenders in rebuilding their lives. ■

FOOTNOTES

[1] Jack is a fictitious man who was conceptualized using information from a variety of sex offender cases I have read about or encountered.

[2] Throughout this article I use male pronouns to refer to sex offenders because men were the subjects of all of the empirical research I reviewed.

[3] Attempts to obtain the original study from the University of Chicago libraries were unsuccessful.

[4] Plethysmograph testing is a procedure in which sexual arousal to various stimuli is measured through penile responses.

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Understanding Rural Mental Health and Service Utilization

by Kelly Anne Kovac

Mental health care professionals at both the policy and practice levels must understand the varying mental health care needs of the populations they serve. This article considers geographic location an important factor in the perception of one's need for professional help for psychological problems and one's ability to access such services. A review of the current literature reveals that the prevalence rates of mental disorders do not differ significantly between rural and urban populations. However, numerous studies find that persons living in rural areas are using mental health care services at much lower rates than their urban counterparts. In this article, the issue of barriers to seeking mental health care services in rural areas is addressed and consideration is made regarding both the physical and mental obstacles that one may have to overcome in his or her treatment-seeking episode. I offer suggestions and highlight opportunities for mental health care professionals to take an active role in contributing to the improvement of mental health care services in rural areas. An understanding of mental health and service utilization in rural communities will enable mental health care professionals to develop effective policy and deliver services to meet the needs of rural residents who are suffering from a mental illness.

As twenty-first century mental health policymakers, practitioners, educators, and students, we must be cognizant of the mental health care needs of rural residents. We must assume active positions in facilitating the changes necessary to improve access to mental health care services in rural communities. From lobbying for changes in current mental health care legislation to our daily work with consumers, we must hold an unwavering commitment to expanding the scope of our professional interests and activities to include rural mental health. The purpose of this article is twofold: to shed light on the issues faced by rural residents in their efforts to access mental health care services and to highlight the opportunities for involvement in professional activities aimed at improving the delivery of mental health care

services to persons living in rural environments.

EMPIRICAL EVIDENCE

A growing body of research examines the mental health and mental health care service utilization among rural populations. Robins, Locke, and Reiger (1991) find in the Epidemiological Catchment Area study few differences in lifetime prevalence rates of psychiatric disorders among persons living in urban and rural areas. Nonetheless, Goldstrom and Manderscheid (1982) and Watts, Scheffler, and Jewell (1986) report that urban dwellers are significantly more likely to use mental health care services than rural residents.

An analysis of mental disorders and service utilization among 1,474 rural and urban women reveals that although mental conditions did not differ across rural and urban sites, rural women utilized services significantly less than the urban women (Gehlert et al., 2002). The authors find that perceived and evaluated mental health problems, attitudes toward seeking treatment for psychological problems, distance from providers, and age were significant predictors of mental health services seeking among the sample of rural women.

In many cases, the lower utilization rates of mental health care services among rural residents may be explained in part by the issues that impede accessing care in rural communities. The Surgeon General's 1999 Report on Mental Health Care in the United States defines "access to mental health services" as the ability to obtain treatment from appropriate professionals for mental disorders (US Department of Health and Human Services, 1999). Issues identified by rural residents as barriers to accessing mental health care services include limited knowledge about services or types of services; lack of referrals to mental health facilities by community members and significant others or other health professionals; cultural valuations or stigma of mental illness; and enabling factors such as lack of transportation (Hill, 1988).

Accessing mental health care services may be determined, in part, by a person's ability to afford the costs of treatment. Higher rates of poverty and lower incomes among persons living in rural areas suggest financial barriers to covering the cost of mental health care. Hartley, Quam, and Lurie (1994) find that rural residents are more likely than their urban counterparts to be living in poverty without adequate health insurance. The lack of adequate health insurance coverage among rural residents might be explained by the findings of Fox, Merwin and Blank (1995) that reveal that agriculture and small business employers are less likely to purchase insurance in rural areas. Long and Marquis (1994) find that inadequate health insurance coverage is associated with reduced health service use.

Government funding decisions may impede the provision of affordable mental health care services for rural residents. For example, in a study of spending decisions for mental health services in Iowa, Rholand and Rhorer (1998) find that counties with fewer people, lower proportions of persons with post-secondary educations, higher proportions of rural and elderly residents, higher rates of poverty, and a higher proportion of income from farms spent less money on mental health services.

The availability of mental health care services may be lacking in rural areas. Decreased access to mental health care services in rural areas might account for some of the differences in mental health care service utilization between persons living in rural and urban areas. Merwin, Goldsmith, and Manderscheid (1995) find that rural areas tend to have fewer specialized services and providers of mental health services than urban areas. Therefore, rural residents with mental disorders may go without appropriate care.

A recent study by Rost, Mingliang, Fortney, Smith and Smith (1998) examines the differences in rural-urban depression treatment and suicidality. The authors hypothesize that because there are fewer per capita providers trained to deliver mental health services in rural areas, depressed rural individuals would receive less outpatient treatment and report higher rates of hospital admittance than their urban counterparts. The results of the study reveal that rural subjects made significantly fewer specialty care visits for depression. Depressed rural individuals were 3.06 times more likely to be admitted to a hospital for mental health problems over the course of 1 year than their urban counterparts. Holzer, Goldsmith, and Carlo (1999) find the most limited range of service providers in the least urbanized nonmetropolitan counties. The authors find a shortage of psychiatrists, child psychiatrists, psychologists and social workers in rural nonmetropolitan areas. Most specialty providers were found in more populated areas.

In the absence of specialized mental health providers, rural residents are likely to rely on a primary care physician to provide treatment for their mental health needs. Reiger, Narrow, Rae, Manderscheid, Locke, and Goodwin (1993) discovered that primary care practitioners do provide a substantial portion of mental health care in rural America. Because most primary care physicians do not specialize in mental health care, they might not have the knowledge needed to accurately diagnose and make a referral for a patient's mental health problems. Hartely, Korsen, Bird and Agger (1998) hold that the recognition of a mental illness and a determination to treat or refer patients exhibiting symptoms of mental illness may be determined in part by clinician training, attitudes and beliefs. Heyman and VandenBoss (1989) note that most

training programs for mental health professionals are geared implicitly or explicitly toward urban situations. The authors emphasize that even the fields of psychiatry and community psychology which stress the nature of the community, have evolved around urban models.

Acceptability is an important factor to consider when examining utilization of mental health care services. Rost, Smith, and Taylor (1993) describe the stigma associated with a psychiatric disorder as a powerful barrier to seeking mental health services, particularly in rural areas. Hoyt, Conger, Gaffney-Valde, and Weihs (1997) examine psychological distress and help seeking in rural America and find that persons in rural places expressed significantly higher levels of stigma related to mental health care than residents of urban areas. The authors conclude that persons living in the most rural environments were more likely to hold stigmatized attitudes toward mental health care and that these views were strongly predictive of willingness to seek care. Rost et al. (1993) studied rural-urban differences in stigma and the use of care for depressive disorders and find that rural residents with a history of depressive symptoms labeled people who sought professional help for the disorder somewhat more negatively than did their urban counterparts. Concerns among rural persons with issues of confidentiality might explain some of the stigma attached to seeking mental health care services in rural areas. Merwin et al. (1995) believe that consumers are concerned that everyone knows about their use of the mental health system resulting in their experiencing increased stigma than when receiving other types of primary care services. The stigmatized label that is often associated with receiving mental health care may carry with it a burden too great to bear within one's own community.

FACILITATING CHANGE

As mental health care professionals, we are faced with the evidence that rural populations have a great need for psychiatric treatment but are not utilizing such services. Furthermore, there are considerable barriers to seeking treatment for mental health problems among rural populations. As agents of change, it is our responsibility to tackle these issues and remain forthcoming in our efforts to develop innovative strategies aimed at improving rural mental health care services.

One important way to influence and create change is through involvement in professional organizations whose missions are aligned with our goal of meeting the mental health care needs of rural communities. The National Institute of Mental Health, the National Association of Social Workers and the National Rural Health Association are organizations that focus on

strengthening the safety net and increasing access to essential mental health care services in rural areas. Each of these organizations encourages active involvement at both the student and professional level.

The National Institute of Mental Health (NIMH) supports rural research activities through the Office of Rural Mental Health Research (ORMHR). Acting director, Grayson Norquist, M.D., MSPH, leads the research activities at the ORMHR, which include research on service delivery in rural areas and the dissemination of important research findings related to the unique conditions of rural areas. The NIMH offers grants for persons interested in exploring important questions about rural mental health. These grants can be obtained by clinicians and academics alike.

The National Association of Social Workers (NASW) acknowledges the need for twenty-first century social work to advocate for the empowerment of people in rural areas. The NASW holds that the social work profession must influence the public policies of the federal, state, and local governments that affect the development and reorientation of service delivery in rural areas. Students and professionals can become active members of the NASW, joining advocates for mental health care reform with foci on the unique needs of rural communities.

The NASW supports social work educators' efforts to incorporate rural content into the curricula of schools of social work, within the context of the present or future accreditation requirements of the Council on Social Work Education (NASW, 2002). At The University of Chicago School of Social Service Administration (SSA), the master's program aims to provide a sophisticated understanding of the person-in-environment. However, the rich educational curriculum offered at SSA does not interface the person-in-environment focus with rural mental health. Support from the NASW may open the door for inclusion of rural mental health as an area of human diversity for future study at SSA. A call is made for innovative academic leaders to develop course curricula that place an emphasis on rural mental health, which encourages students to think further and develop ideas about effective mental health service delivery to persons living in rural areas.

The National Rural Health Association (NRHA) is a national membership organization whose mission is to improve the health and healthcare of rural Americans and to provide leadership on rural issues through communication, education, and research. The NRHA's commitment to strengthening the rural health care infrastructure includes a focus on rural mental health issues. The NRHA has made funding requests for several key rural health programs to the Bush Administration for the Fiscal Year 2003 Budget. The NRHA rec-

ommends that the President's Budget allocate $250 million dollars to the National Health Service Corps (NHSC), which plays a critical role in providing primary care services to rural underserved populations. Funding would support the additional clinicians needed to begin eliminating the 740 Mental Health Professional Shortage Areas (MHPSAs). The NHSC has identified clinical psychologists, psychiatrists, psychiatric nurses, clinical social workers, and marriage family counselors as mental health providers eligible for loan repayment in exchange for service in MPHSAs (NRHA, 2002).

OUR PROFESSIONAL RESPONSIBILITY

Whether we hold positions as mental health policymakers, clinicians, educators, or students, it is important to consider the environments that house those we serve. Drawing from a professional knowledge base that provides an understanding of the differing needs of various populations will allow us to develop policies aimed at breaking down the barriers to accessing care created by one's geographic location. When we try as clinicians to understand why a psychiatrically impaired client is not coming in for services, we must take into consideration how his perception of mental illness and mental health care treatment are influenced by his place of residence. As educators, we must inspire students to challenge their conventional ideas about the general application of mental health care services among urban and rural populations. And as students, we must be open to learning about the mental health care needs of populations with which we might not be familiar or to which we have not previously paid interest.

We must remain astute in our roles as policymakers, practitioners, educators, and students, looking beyond the presented problems toward innovative and sound resolutions aimed at improving rural mental health care. It is our responsibility to update ourselves on the current literature that examines the mental health care needs of various populations. Our involvement in professional organizations that utilize the collective action of mental health workers to advocate for policies aimed at improving service delivery in underserved rural areas is imperative. We are already or will soon become the mental health care professionals of the twenty-first century and with that title holds the awesome responsibility of understanding and meeting the unique needs of the populations that we serve. ■

For more information about the aforementioned professional organizations please contact the following sources:

National Rural Health Association
One West Armour Blvd. — Suite 203
Kansas City, Missouri 64111-2087

National Institute of Mental Health
Office of Rural Mental Health Research
Greg S. Norquist, M.D., MSPH
Acting Director

National Association of Social Workers
750 First Street NE, Suite 700
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The School of Social Service Administration
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An Evaluation Framework for Measuring Outcomes of Dually Diagnosed Homeless Individuals in Flexible and Integrated Treatment Programs

by Richard Meldrum

Homeless individuals who are dually diagnosed have generally received poor services in treatment programs. Either the programs do not integrate mental health treatment with substance abuse treatment or the integrated programs have been too rigid to address complex dual diagnosis issues. Recently, flexible and integrated treatment programs have started to crop up to address this service gap. However, these programs often lack comprehensive evaluation data. Drawing on research with a stages of change, integrated treatment program, I explore potential ways to evaluate the short- and long-term outcomes of similar programs. The development and implementation of a comprehensive evaluation strategy is an important step to assessing the value of flexible and integrated dual diagnosis treatment programs.

Traditionally, dually diagnosed homeless (DDH) individuals have been treated either in mental health clinics or substance abuse treatment centers. These alternatives often result in high client dropout rates since they ignore the second diagnosis (Blankertz and White, 1990). When treatment is integrated, most programs employ a strict abstinence policy for substance abuse and require mental health medication compliance. Because recent research shows mixed results of these programs, some developers have switched to more flexible program goals (Carey, 1996). In contrast to the traditional treatment programs, the flexible programs do not necessarily demand abstinence or medication compliance. However, this transition has made client and program evaluation difficult. Therefore, I propose an evaluation strategy based on the analysis of an integrated DDH program that imbeds a flexible stage of change model within a continuum of housing structure. Before turning to my evaluation strategy, however, I provide a brief definition and description of the DDH population.

DEFINITION AND DESCRIPTION OF DDH POPULATION

The program discussed throughout this article categorizes people as dually diagnosed if they have a serious mental illness (e.g., schizophrenia, delusional disorders, schizoaffective disorders, mood disorders, borderline personality disorders, etc.) and a co-occurring substance disorder (e.g., abuse of alcohol, opiates, cocaine, etc.).[1] This definition is consistent with the literature referenced throughout this article.

Since the late 1980s the co-occurrence of mental illness and substance abuse has hovered around 17 percent within the homeless population (Burt, 1989; Tessler and Dennis, 1989; Burt, 1999). In general, program developers have only recently recognized dually diagnosed individuals as a significant subpopulation of the homeless community (McHugo et al., 1995). The consequence of this oversight has been demonstrated through the lack of services targeted directly at DDH individuals. Accordingly, members of this community often fall through the cracks of service provisions aimed at mental illness or substance abuse rather than both diagnoses. When DDH individuals are treated in only one system the second diagnosis is often ignored, resulting in a high dropout rate (Blankertz and White, 1990).

Although poor services remain a problem, this trend has begun to change through increased understanding and research into the composition of this group. Specifically, researchers and program developers are beginning to understand this group's extremely heterogeneous nature. Indeed, the MISA population differs not only in terms of demographics but also in severity of their mental illnesses and addictions (Carey, 1996; Drake, Osher, and Wallach, 1991). Complicating matters further, DDH individuals have higher incidences of general medical illness, legal problems, and skills deficits among their many other difficulties (Carey, 1996; Drake et al., 1991; Fischer, 1990). Most likely, these complications are the result of their severe substance abuse and mental illness impairments.

DESCRIPTION OF THE ROBESON CENTER

Opened in late 2000, the Robeson Center (Robeson) offers housing, treatment, and case management supports to DDH adults.[2] In order to serve its residents, the center provides services to accomplish two goals: to facilitate participants' development of the necessary skills to manage their multiple disorders and to obtain and maintain permanent autonomous living. To meet these goals, Robeson administration mirrors its residents' stabilization stages using a

continuum of housing and treatment program. In this manner, Robeson represents a new kind of agency that links housing and treatment geared toward DDH individuals.

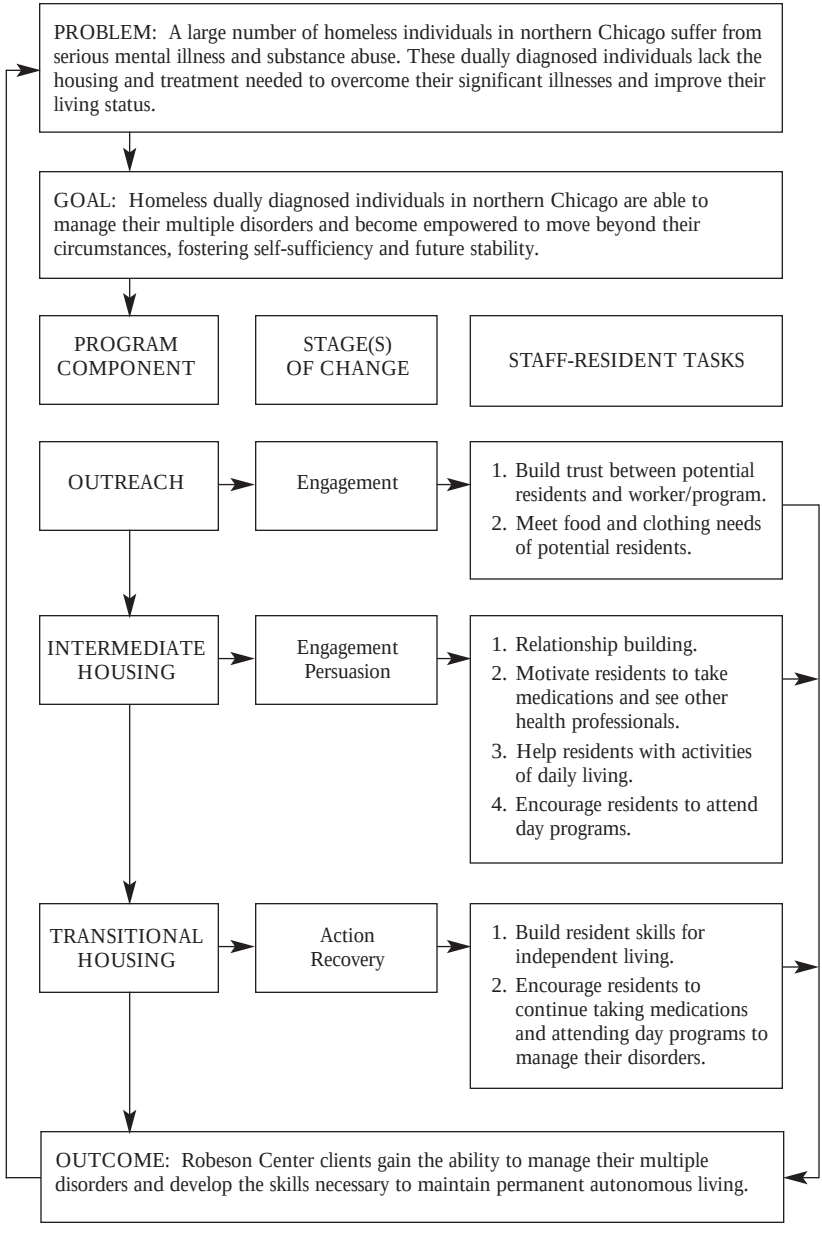
Robeson's services are rooted in a growing theoretical belief shared by a number of researchers. These researchers take into account the enormous complexities and vulnerabilities of the DDH population and, as a result, advocate for integrated and flexible treatment approaches (see Blankertz and White, 1990; Carey, 1996; Drake et al., 1991). This approach enables individuals to simultaneously progress through substance abuse and mental illness treatments in stages consistent with their level of diagnosis.

These flexible and integrated programs serve not only organizational needs but also may have an advantage over traditional programs. They meet organizational needs since many clinicians and administrators support integrating treatment within one system or setting. Indeed, this arrangement removes the burden of coordination between multiple agencies (Drake et al., 1991). Additionally, research finds that housing provisions may be the cornerstone of care for DDH individuals (Drake et al., 1991; Hopper, 1989). These housing provisions provide stability for potential residents during their struggle to gain control over their multiple problems.

In concordance with the literature, Robeson has developed three program components that form a continuum of program components: outreach, intermediate housing, and transitional housing (figure 1). These components attempt to provide the necessary flexibility for dually diagnosed individuals to progress at a pace consistent with their diagnoses. Furthermore, Blankertz and White (1990) imply that the individual characteristics of MISA individuals (e.g., acceptance of restrictive environments, desire for self-determination, tolerance of high expectations, willingness to strive for abstinence, etc.) may determine how much structured housing they prefer or need in order to address their mental illness and substance abuse issues.

Consequently, this housing structure necessitates an equally flexible treatment philosophy since a strict one would fail to differentiate the beneficial aspects of each housing component. Therefore, Robeson administration employs the philosophy that change occurs through a series of stages (Stellon, 2001; Osher and Kofoed, 1989; Prochaska and DiClemente, 1986; Prochaska and Prochaska, 1999). Specifically, Osher and Kofoed (1989) note that MISA individuals generally pass through four stages on their way to recovery: engagement, persuasion, active treatment, and relapse prevention. Initially, clients become engaged in the treatment relationship (figure 2). During the persuasion stage, clinicians work to motivate their clients' desire to change their self-

FIGURE 1: ROBESON CENTER LOGIC MODEL



destructive behavior. Clinicians may, for example, persuade a resident that substance abuse is a problem with high personal costs and that greater health and happiness can be attained by decreasing her substance use. After clinicians have persuaded substance abusers to reduce substance use, active treatment strategies can help them develop the necessary skills and supports to eventually achieve abstinence. Finally, after achieving stable abstinence, they can be assisted to maintain whatever resources and behavioral changes are needed to prevent relapse. These stages of change serve as the foundation for Robeson's housing components.

FIGURE 2: STAGES BY PROCESS OF CHANGE

STAGES OF CHANGE

	Engagement	*Persuasion*	*Active Treatment*	*Relapse Prevention*
Process	Build trust and relationship with MISA individual	Individual is willing to discuss his problem behavior(s)	Individual is actively involved in treatment	Individual is in treatment and has maintained at least 6 months of abstinence

DESCRIPTION OF PROGRAM COMPONENTS

Outreach: Engagement

The essential function of Robeson's outreach is to initiate the process of engagement with potential residents. To fulfill this function, Robeson clinicians provide outreach services to the streets and local social service agencies several times a week. In the agencies, outreach workers often meet with individuals who were referred by the agency's staff. However, street outreach is focused entirely on providing individuals with services and items that they specifically request. For example, a Robeson worker related a story about an individual who was obviously mentally ill but requested only clothing. Since the worker was attempting to gain the individual's trust, he provided clothing without attempting to address the mental health issue. The worker's example highlights the outreach effort's engagement function. This engagement process involves gaining the trust of an individual and continues throughout the individual's interactions with the agency. Engagement is essential to establish an effective relationship between the workers and the individual (Blankertz and White, 1990). Depending on the DDH individual's level of engagement and willingness to pursue treatment, she may be accepted into the program.

Intermediate Housing: Engagement and Persuasion

The overall goals of the intermediate housing component are to continue building a trusting relationship with the resident, stabilize the resident's multiple problems, and begin working toward abstinence. When individuals officially enter the program, they come into the intermediate housing section. This section allows a resident an indefinite length of stay depending on the individual's progress, and housing is provided at no charge to him. However, Robeson requires its residents to adhere to specific expectations (e.g., no alcohol or illegal drugs on premises, no weapons or fighting on premises, no abusive or threatening language, must keep room, person, and clothes clean, etc.) to help ensure the safety and comfort of residents and staff. Since most residents may be eligible for either SSI or Medicaid, Robeson case managers also work with the residents to secure these entitlements.

Aside from attending to residents' basic needs, Robeson workers also assess the residents' dual problems. Robeson's psychiatric staff examines the residents' level of mental illness in this stage and prescribes appropriate medications to stabilize the illnesses. Staff nurses then have the responsibility to offer medications as prescribed. Treatment integration in this stage consists mainly of workers encouraging residents to stabilize their mental health through taking medications and their substance abuse through reduced substance use. Utilizing these measures and appropriate group meetings (e.g., Alcohol/Narcotics Anonymous), Robeson believes that residents will become increasingly aware of their problem behaviors and more willing to change those behaviors.

Transitional Housing: Action and Recovery

As the worker-resident alliance strengthens and residents maintain abstinence along with mental health stability, they can move to the center's transitional housing program. Once residents move into this stage, Robeson expects them to attain the level of abstinence where occasional lapses, but not days of problematic use, may occur. In this stage residents must pay rent equal to a third of their income (if they have an income) and are limited to a maximum stay of 24 months. Additionally, Robeson workers assist them with further treatment and daily living skills that will enable residents to maintain permanent independent living and the ability to manage their disorders. Toward the end of a resident's stay, Robeson workers will help residents find independent housing and link them to other social services if needed.

EVALUATION QUESTIONS AND RECOMMENDATIONS

In order to understand the impact of Robeson's programming, its administrators must consider at least three key evaluative questions. First, where do the residents enter the program? As stated earlier, Robeson provides outreach to the shelters and the streets in northern Chicago. However, if the vast majority of the clients come from social service agency referrals, then direct street outreach might be unnecessary to attract program participants. Robeson will most likely receive more residents from referrals than from street outreach since the instability of the DDH population may detract from regular street contact (Drake et al., 1991). Furthermore, referred clients may be easier to engage since they have at least developed a relationship with a social service worker and demonstrated willingness to be assessed by Robeson workers.

Second, how long does it take and how much does it cost for one resident to progress through the program? The intermediate stage presents the greatest opportunity for residents to linger and costs to grow. The residents in this stage not only have the lowest expectations of Robeson residents, but they also do not pay rent. Without higher expectations, these residents could easily remain in the center for long periods of time. If this delay is occurring unnecessarily, then the administration may need to increase its expectations from residents.

Third, is the program effective at fulfilling its mission statement? This question is the fundamental question that Robeson needs to address. Its program developers have taken a nontraditional approach to treating DDH individuals and need to know if the program does what is proposed. If it is not fulfilling the mission to provide services that facilitate residents' development of the necessary life skills and ability to manage their multiple disorders, then the approach should be changed.

Since poor evaluations remain a major criticism of nonabstinence treatment programs, a comprehensive evaluation toolbox must be employed. Indeed, Ogborne and Birchmore-Timney (1999) note that harm reduction program proponents often make promises of greater cost-effectiveness and better outcomes, but they support their claim with rhetoric rather than evidence. For this reason, evaluation strategies are important not only to ensure quality treatment for those receiving it but also to establish or eliminate nonabstinence programs from the field. To answer the questions posed above, the following measures will be discussed as a set of recommended evaluation tools: Substance Abuse Treatment Scale, medication compliance, activities of daily living development, program participation, housing outcomes, addiction out-

comes, and mental illness outcomes. These evaluation measures cover the spectrum of intermediate and long-term outcomes as well as individual and programming performance levels.

First, the Substance Abuse Treatment Scale (SATS) serves as the foundation for the evaluation strategy. The SATS is the result of a New Hampshire Division of Mental Health (NHDMH) seminar that elaborated on the stages of change model discussed above (see appendix). The seminar participants expanded the model into eight stages with more explicit criteria. The NHDMH then applied the scale in community mental health centers to track the progress of clients who were dually diagnosed throughout a 3-year study. Researchers found that SATS was a useful tool to summarize and track the progress of clients with mental illness in substance abuse treatment (McHugo, et al., 1995).

The major strength of SATS for the Robeson Center lies in its fit with the program. Indeed, the measure not only fits with the program's philosophy but also with the client population. The expanded stages of change model in SATS would be easy to utilize with Robeson's preexisting methodology since they both build from the same general format. Additionally, the measure is the only one designed, developed, and standardized for dually diagnosed individuals.

On the other hand, SATS's primary weakness lies in the realm of its newness. Robeson clinicians would need training to learn to use the measure effectively. However, McHugo et al. (1995) note that with "modest training and reasonable familiarity with their clients, clinicians can use SATS consistently and meaningfully" (p. 766). This training could progress more quickly for Robeson clinicians given their familiarity with the basic stages of change model.

The programming benefits that SATS offers lies in resident tracking. From the initial program overview, a potential logjam could easily occur in the intermediate housing stage without proper evaluation. Given the combination of free rent and low expectations, residents could linger unnecessarily in this program element, increasing costs and preventing the agency from helping other people. Applying SATS every 6 months, as NHDMH recommends, would allow Robeson workers to maintain an individual's residency in the appropriate setting. Therefore, SATS enables administrators to understand how long residents take to move through the program and how effective the program is in the intermediate time frame.

The second measure, medication compliance, is a very straightforward measure. Since residents are encouraged, but not absolutely required, to take medications that control their mental illnesses, an understanding of how many

people actually comply with these requests is important. Indeed, if residents are consistently taking their medications, then they are exhibiting more control over their mental illness. Thus, this measure indicates a resident's progression through the stages of change (Stellon, 2001).

Third, activities of daily living (ADLs) and program participation are good resident measures since they can indicate a level of engagement and progression toward independence. When residents first enter Robeson, workers identify the expectation that they will keep their clothes, their room, and themselves clean (Stellon, 2001). Additionally, residents are expected and encouraged to attend day programs at a sister agency. These programs range from traditional 12-step programs to educational seminars on nutrition. As the resident progresses through the housing components, Robeson workers expect residents to complete more ADLs and participate in more day programs. Therefore, monitoring residents' compliance indicates how well they meet program expectations and how capable they are of independent living.

Finally, in order to determine the program's effectiveness, Robeson must track individual housing outcomes, rehabilitation outcomes, and mental illness control after residents leave the program. The program's mission statement claims that "upon successful completion…the participant will have developed the skills necessary to obtain and maintain permanent autonomous living and the ability to manage their multiple disorders" (Stellon, 2001). Thus, these measures assess the program's ability to accomplish that end. However, Robeson evaluators may have difficulty tracking former program participants after they leave the program. This dilemma might be alleviated by offering former residents assistance (e.g., groceries, counseling, etc.) that would tie them to the organization long enough to track their outcome status and smooth their transition.

CONCLUSIONS

The specific aim of this analysis is to suggest an evaluation strategy for program and participant outcomes using the Robeson Center as a model. This proposed strategy provides a means to test flexible program structures that do not necessarily demand abstinence or medication compliance from DDH individuals. Although this article is not intended as an endorsement for a particular program structure, the rise in flexible treatment programs demands an appropriate evaluation toolbox. Thus, the creation of such an evaluation strategy is an important step in properly understanding the effectiveness of these programs. ■

APPENDIX

SUBSTANCE ABUSE TREATMENT SCALE (SATS)[3]

Instructions: *This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last 6 months. If the person is in an institution, the reporting interval is the time period prior to institutionalization.*

1. PREENGAGEMENT: The person (not client) does not have contact with a case manager, mental health counselor, or substance abuse counselor.

2. ENGAGEMENT: The client has had contact with an assigned case manager or counselor but does not have regular contacts. The lack of regular contact implies lack of a working alliance.

3. EARLY PERSUASION: The client has regular contacts with a case manager or counselor but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

4. LATE PERSUASION: The client is engaged in a relationship with case manager or counselor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g., Antabuse) may be involved in reduction.

5. EARLY ACTIVE TREATMENT: The client is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least 1 month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.

6. LATE ACTIVE TREATMENT: The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than 6 months.

7. RELAPSE PREVENTION: The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least 6 months. Occasional lapses, not days of problematic use, are allowed.

8. IN REMISSION OR RECOVERY: The client has had no problems related to substance use for over a year and is no longer in any type of substance abuse treatment.

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FOOTNOTES

[1] The term "mentally ill substance abuser", or MISA, will be used interchangeably with the term "dually diagnosed" following the field's general trend.

[2] The name of this agency has been changed to protect confidentiality.

[3] This scale measures an individual's progress through the stages of change for substance abuse treatment.

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RICHARD MELDRUM is a second year student at the School of Social Service Administration. He will be graduating June 2002. Upon graduation, he hopes to work for either a healthcare or education organization doing policy and research. Prior to attending SSA, he earned a bachelor's and master's degree in comparative religion at Western Michigan University.

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