Chapter Eight

Sensitivity to Culture in Systems of Care

Racial and Ethnic Disparities in Access to Mental Health Services for Youth in the United States

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Introduction

Despite significant public and scientific attention to the problem of racial and ethnic disparities in mental health service delivery in recent years (Burns, 1991; Manderscheid, Brown, Milazzo-Sayre, & Henderson, 2002; Pottick, Issacs, & Manderscheid, 2002; US Department of Health and Human Services, 2001), there remain many unanswered questions, especially for youth. In part, because youth represent only about a quarter of the total mental health service population (Milazzo-Sayre et al., 2001), we have less information about racial and ethnicity-based inequities in their access to services than we have about the adult population. There are some notable exceptions (see Kataoka, Zhang, & Wells, 2002). Indeed, a large portion of our understanding of barriers to care is derived from the adult literature. For example, Snowden and Holschuh's (1992) study of racial and ethnic effects on service use among severely mentally ill adults found that African Americans were more likely than other ethnic groups to use psychiatric emergency services and to experience rehospitalization, corroborating earlier research of national trends (Cheung & Snowden, 1990) which showed that minorities used hospital-based services disproportionately relative to non-minorities. More recent, smaller scale research (Snowden & Hu, 1997) suggests that the organization of different systems of care counteract these observed racial and ethnic patterns. On the one hand, minority youth may be *more* likely to be hospitalized for their mental health problems than non-minority youth, if national patterns regarding hospitalization of adults hold for youth. On the other hand, a few studies of the youth population suggest potential barriers in access to inpatient care: minorities have a lower risk of hospitalization than non-minorities (Chabra, Chávez, Harris, & Shah, 1999) and minority youth are less likely than non-minorities to receive treatment (Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995). Thus, minority youth may be *less* likely to receive inpatient services than non-minority youth.

This research describes use of the most recent available national data to test these alternative hypotheses. We improve upon methods of earlier research that generally investigated zero-order relationships with few controls; using unprecedented multiple indicators of illness, we control on youth's need for services to determine whether race and ethnicity affect their selection into inpatient versus outpatient services.

Method

Data Source

The study uses data from the 1997 Client/Patient Sample Survey (CPSS) collected by the Center for Mental Health Services (CMHS). Within 1,599 randomly selected treatment programs, detailed questionnaires were completed from medical records of randomly selected youth who were admitted to inpatient, outpatient or residential treatment facilities (unweighted $N = 4{,}035$) or who were under care in these organizations on May 1, 1997 (unweighted $N = 4{,}014$; see Milazzo-Sayre et al., 2001). The survey oversampled youth, thereby allowing reliable national estimates of mental health service utilization for different subgroups in the population for the first time.

Study Sample

Analysis is based on 3,468 youth (0 through 17 years old, weighted N = 1,221,857) admitted for inpatient (n = 614; weighted n = 278,873; 22.8%) or outpatient services (n = 2,854; weighted n = 942,984; 77.2%) over the course of the year. The study sample excluded 21 youth admitted in facilities in the U.S. Territories (i.e., Guam, Puerto Rico, and the U.S. Virgin Islands), and excluded youth admitted to residential treatment facilities (n = 444; weighted n = 65,949; 5.0%). A residual racial and ethnic group of 102 (2.2%) youth (Asians, Pacific Islanders, American Indians, and Alaska Natives) was further excluded due to its insufficient sample size for reliable analysis. Youth inpatient facilities included state or county mental hospitals (6.8%), private psychiatric hospitals (52.5%), non-federal general hospitals (30.6%) and multi-service mental health organizations (10.1%).

The analytic sample included three racial and ethnic groups of 2305 non-Hispanic Whites (hereafter W; weighted n = 809,504; 66.3%), 685 non-Hispanic Blacks (B; weighted n = 234,948; 19.2%) and 478 Hispanics (H; weighted n = 177,405; 14.5%).

Measures

Figure 1 details the coding categories for sociodemographics of age, gender, living situation, and principal source of payment. Indicators of illness were measured by: (a) principal DSM or ICD diagnosis (American Psychiatric Association, 1994; World Health Organization, 1980, respectively), (b) number of assigned DSM or ICD diagnoses, and (c) severity of illness. DSM or ICD principal diagnosis were coded into ten categories of disorder: disruptive behavior (30.7%), mood (20.7%), adjustment (16.9%), anxiety (7.3%), developmental or pervasive (5.3%), psychotic (2.6%), alcohol or drug abuse or dependence (3.4%), personality (2.0%), social conditions (V-codes; 3.7%), and other (7.1%). The number of diagnoses was constructed by the examining whether a child had no assigned psychiatric diagnosis (7.1%), a single principal DSM or ICD diagnosis (63.8%), or both a single and secondary or dual DSM or ICD diagnosis (29.1%). Severity of illness was measured by the ten-item Global Assessment of Functioning (GAF, American Psychiatric Association, 1994) scale for reporting overall functioning on Axis V of the DSM-IV. Scores ranged from 1 to 100, allowing for rating individuals from severely impaired (needs constant supervision) to superior functioning in all areas. In this sample, the GAF ranged from 1 to 100 (mean M = 52.6, SE = 0.24). Using CMHS standards for conservative estimates of serious impairment due to emotional disturbance (Friedman, Katz-Leavy, Manderscheid & Sondheimer, 1998), we contrasted scores between 1 and 50 with scores between 51 and 100.

Analysis

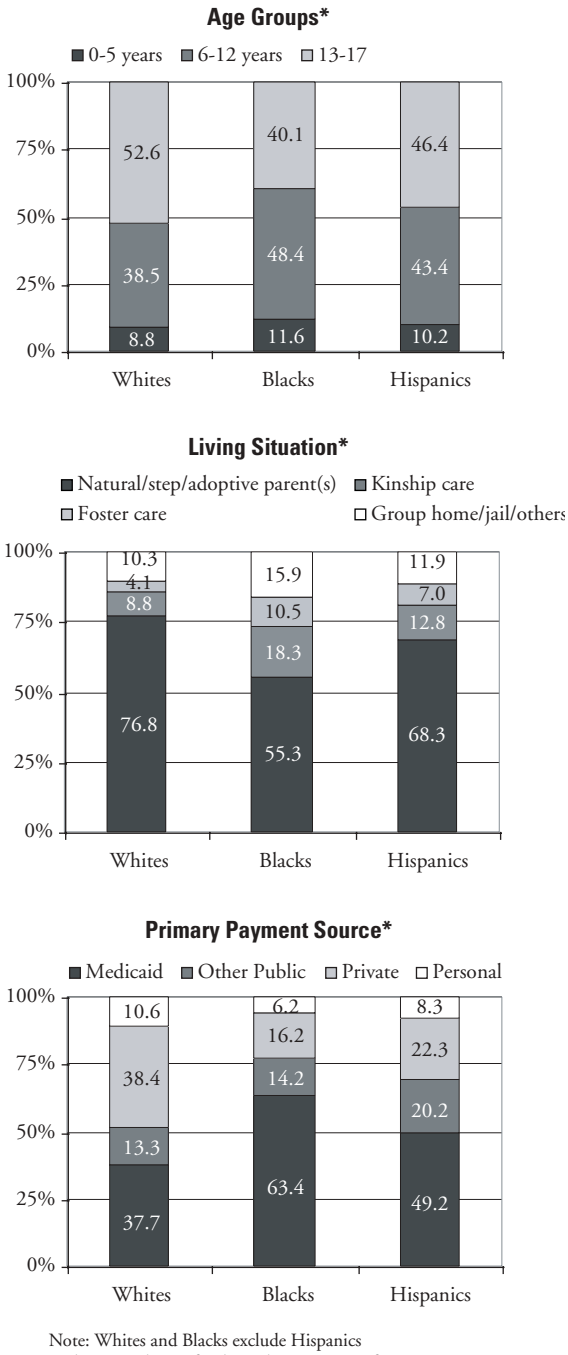
Traditional chi-squared analysis of contingency tables was used to test bivariate relationships, and two-sample t-tests were used to examine which racial and ethnic groups differed from each other on a given characteristic. To account for the complex survey sample design, SUDAAN software was used to adjust standard errors and degrees of freedom for the test statistics.

Results

Socio-demographic Characteristics Among Black, Hispanic and White Youth

There were three key significant socio-demographic differences by race and ethnicity in the youth service population (Figure 1). Minorities tended to be younger than non-minorities. Minorities tended to live away from biological/step/adoptive parents while non-minorities had more stable living situations. Minorities' services tended to be publicly funded, while non-minorities tended to pay with private insurance. There were no statistically significant differences between minorities and non-minorities in gender.

Figure 1
Socio-demographic Characteristics of Youth Admitted to U.S. Mental Health Services by Race and Ethnicity: 1997 National Estimates (*N* = 1,221,857; Unweighted *n* = 3,468)



Note: Whites and Blacks exclude Hispanics
* Chi-squared test of independence was significant: $p < .05$

Indicators of Illness

The three groups were statistically comparable in their illness profiles as indicated by type of diagnosis, number of diagnoses, and GAF scores (not tabled). Approximately two-thirds of youth in each race and ethnic group were assigned one of three disorders: disruptive behavior, mood or adjustment (W = 69.3%; B = 68.5%; H = 64.6%). Nearly 30% of youth in each race and ethnic group (W = 29.9%; B = 26.9%; H = 27.8%) were diagnosed with two disorders. The three groups were no different in the proportion with GAF scores of ≤ 50 (W = 39.3%; B = 43.5%; H = 45.4%).

Racial and Ethnic Factors Associated with Inpatient vs. Outpatient Care

Whites, Blacks, and Hispanics were admitted to either inpatient or outpatient care in relatively comparable proportions. About one-fifth (W = 23.8%; B = 19.6%; H = 22.5%) were admitted to inpatient care and about four-fifths (W = 76.2%; B = 80.4%; H = 77.5%) received outpatient care. Thus, without controlling on illness, the three racial and ethnic groups were selected into the two different settings in statistically equivalent proportions.

We then controlled on the three illness indicators (type of diagnosis, number of diagnoses, GAF) to determine if Whites, Blacks and Hispanics were selected into the same settings given comparable illness profiles (see Figure 2). Disturbingly, as levels of severity increased (i.e., GAF scores ≤ 50, dual diagnosis, presence of disruptive behavior disorder), minorities were less likely than non-minorities to receive inpatient services. Specifically, among youth with GAF ≤ 50, Blacks (24.4%) were significantly less likely than Whites (35.2%) to receive inpatient services [t = -2.52, p(two tailed) = .012]. Among youth with dual diagnosis, Hispanics (21.2%) were significantly less likely than Whites (38.0%) to receive inpatient services [t = -3.28, p(two-tailed) < .001]. Among youth diagnosed with disruptive behavior disorder, Whites (15.9%) were significantly more likely to receive inpatient services than Blacks (8.5%) [t = 2.03, p(two-tailed) = .04] and Whites were nearly significantly more likely than Hispanics (8.9%) [t = 1.71, p(two-tailed) = .09] to receive inpatient services. There were no racial and ethnic differences for other diagnoses.

Figure 2
Proportion of Youth Admitted to U.S. Inpatient or Outpatient Mental Health Services by Race and Ethnicity, Stratified by Illness Indicators: 1997 National Estimates (*N* = 1,221,857; Unweighted *n* = 3,468)

Illness Indicator [a]	*Inpatient Services*	*Outpatient Services*
GAF rate ≤ 50*	Blacks < Whites	Blacks > Whites
Dual diagnosis***	Hispanics < Whites	Hispanics > Whites
Disruptive behavior*	Blacks < Whites	Blacks > Whites

[a] Note: Whites and Blacks exclude Hispanics.
Two-tailed t-test of differences was significant: *p < .05; **p < .01; ***p < .001

Discussion

The study used nationally representative data from the 1997 Client/Patient Sample Survey and multiple indicators of illness to examine whether minority and non-minority youth were selected into the same type of setting (inpatient or outpatient), if they had similar illness profiles. Results showed that as level of severity increased, minorities were less likely than non-minorities to receive inpatient services, and more likely to receive outpatient services. This finding is especially important because other research shows that minorities receiving services in the specialty mental health system and in public mental health facilities tend to be over-represented relative to their numbers in the general population (Pottick et al, 2002; Pottick et al., in press; Mason & Gibbs, 1992). Thus, even though a greater proportion of minorities than non-minorities in the population receive care, they do not appear to receive comparable

care, given their illness profiles. While future research is necessary to understand the influence of insurance that also may be associated with race and ethnicity and unequal care (Pottick, Hansell, Gutterman, & White, 1995), these results raise serious questions about how to ensure comparable mental health care for minority and non-minority youth.

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Effective Mental Health Interventions for African-American Children Attending Urban Schools

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Introduction

School-based mental health (SBMH) services are one way to provide more services for African-American children and families who are living in urban areas. This summary reviews select interventions that show promise for improving outcomes for these families. Additionally, the role of fidelity studies in transporting effective interventions to SBMH clinics is discussed.

Ensuring Fidelity

Fidelity studies typically focus on examining whether treatment was provided as planned (Moncher & Prinz, 1991). When this type of research is conducted as part of program evaluation activities and results are related to children's performance on dependent variables, then knowledge about whether the treatment is related to improved outcomes is enhanced (Hoagwood, Burns, Kiser, Ringeisen, & Shoenwald, 2001; Shoenwald & Hoagwood, 2001). For example, Scott Henggeler and others have reported that Multisystemic Therapy (MST), which includes family therapy and case management services, is an effective intervention for improving functioning for adolescents experiencing conduct problems (Henggeler, Shoenwald, & Pickrel, 1995). Currently, the effectiveness of this systemic approach is being tested in new areas (Ellis, Naar-King, Frey, Rowland, & Greger, 2003; Henggeler, 2003; Harris & Mertlich, 2003). Studies examining whether MST is effective in SBMH clinics need to be conducted, and these studies will necessarily include a fidelity component.

Many different research techniques can be used to conduct fidelity studies (Bond, Evans, Salyers, Williams, & Kim, 2000). One way to do so is to videotape therapy sessions and have observers code tapes to determine whether the intervention was delivered as intended (Holloway & Neufeldt, 1995; Nabors & Lehmkuhl, 2002). Researchers also have used fidelity checklists, upon which therapists or clinicians record whether they have delivered interventions as specified in treatment manuals or as directed by their supervisors (Everhart & Wandersman, 2000; Schoenwald, Henggeler, Brondino, & Rowland, 2000). Using fidelity studies to determine whether interventions can be delivered in SBMH clinics serving inner-city youth is an important step in assessing the transportability of clinic-based treatment to a community setting. Two examples of school-based studies in which fidelity checks were conducted are presented in Table 1.

Table 1
Examples of Research on Transportability of Interventions

Authors	*Fidelity Measure*	*Summary*
Everhart & Wandersman (2000)	Used a fidelity checklist to record teacher use of materials and the integrity with which teachers implemented a prevention curriculum.	Discussed how evaluation and quality assurance activities can be used to improve the implementation of a school-based character education and mentoring program. Teacher compliance with implementation plans was judged to be good.
Harachi et al. (1999)	Used behavioral observations to document teacher use of teaching strategies and procedures.	Examined the level of staff exposure and extent of incorporation of a prevention program to reduce adolescent risk behaviors into classroom teaching. Results indicated that adherence to teaching practices was related to improved student behaviors.

Promising Interventions

Several interventions may be effective for treating mental health problems faced by minority youth (typically African-American children) attending urban schools. For instance, Marc Atkins and his colleagues have shown that the Parents and Peers as Leaders in Schools (PALS) program has a positive influence on children's classroom behavior and academic performance (Atkins, Frazier, Adil, & Talbott, 2003). This intervention focuses on involving parents in schools, collaboration between clinicians and teachers, and recruits peers as tutors. John Lochman and his colleagues have developed and examined the efficacy of the Anger Coping Program, which was developed to change cognitive processing to improve anger management skills for elementary school-aged boys. Both of these interventions emphasize teaching and empowering children (Lochman, Curry, Dane, & Ellis, 2001).

Similarly, Tucker and her colleagues (Tucker & Herman, 2002) have developed an after-school program that shows promise as an intervention to improve school functioning for African-American children from low-income families. Tucker (1999) proposed that African-American children need enhanced practice and encouragement to learn achievement-oriented classroom behaviors. When these children improve their achievement skills, both academic performance and social interactions show positive outcomes. Tucker and her colleagues are currently conducting research to examine the effectiveness of her program (Tucker & Herman, 2002). Further studies are needed, however, to see if this intervention can be used successfully in SBMH clinics.

Kendall and Treadwell (1996) reviewed Kendall's Coping Cat Program and related interventions, which have a cognitive-behavioral focus and are designed to ameliorate symptoms related to anxiety disorders in children. Many African American children in urban areas face anxiety and stress related associated with living in neighborhoods affected by violence. Relaxation training and other techniques incorporated in Kendall's program, and the manualized treatment he has developed for helping youth manage anxiety, may provide excellent, short-term treatments for children attending SBMH clinics.

Mentoring programs may be another way to promote positive behaviors and academic achievement at school (Vance, 2002). Interestingly, the adults who deliver mental health promotion activities may not need professional degrees to provide effective interventions. Leff and colleagues have developed a program that is designed to reduce aggressive behavior and promote positive interactions on the playground (Leff, Nabors, & Blom-Hoffman, 2001). The interventions for this program are delivered by paraprofessionals. This may be a very cost-effective way to promote positive outcomes for children attending urban schools where extensive funds are not available.

References presenting an overview of effective interventions for children are listed in Table 2. Future research should examine issues related to implementation of these interventions in urban SBMH clinics.

Conclusion

Clinicians and administrators may need to be convinced of the importance of implementing evidence-based interventions and conducting fidelity studies. Several resources are available for educating others about the importance of school mental health services.

One document that can be used to inform policy makers and funders is available on the website for the Center for Mental Health in Schools, and is entitled, *Mental health in schools: Guidelines, models, resources, and policy considerations* (Policy Leadership Cadre for Mental Health in Schools, 2001). Another document that may be useful for planning research and implementing programs to promote children's mental health in schools is the concept paper written by national leaders entitled, *Mental health, schools, and families, working together for all children and youth: Toward a shared agenda* (National Association of State Mental Health Program Directors, 2002); this paper outlines future goals for SBMH clinics. Moreover, ideas for promoting transportability of interventions and disseminating findings about evidence-based treatments can be found in the *Blueprint for change* document (National Advisory Mental Health Council, 2001).

Table 2
Suggested Literature on Effective Interventions

Evidence-Based Interventions
Burns, B. J., & Hoagwood, K. (2002). *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York: Oxford University Press.
Christophersen, E. R., & Mortweet, S. L. (2001). *Treatments that work with children: Empirically supported strategies for managing childhood problems.* Washington, D. C.: American Psychological Association.
Hibbs, E. D., & Jensen, P. S. (1996). *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice.* Washington, D. C.: American Psychological Association.
Pfeiffer, S. I., & Reddy, L. A. (Eds.), (2001). *Innovative mental health interventions for children: Programs that work.* New York: Haworth Press.
Effective Research in School Mental Health
Hoagwood, K., & Erwin, H. D. (1997). Effectiveness of school-based mental health services for children: A 10-year research review. *Journal of Child and Family Studies, 6,* 435-451.
Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3,* 223-241.

In summary, improving the evidence base for effective school-based interventions remains an important goal (Hoagwood & Erwin, 1997). Conducting fidelity studies to examine how interventions are implemented may provide information about changes or modifications that may be needed to effectively transport clinic-based interventions to SBMH clinics. Learning about which interventions can be transported effectively for African-American youth attending urban schools will be important to improving the quality and cultural appropriateness of care for these children and their families.

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SOC Administrator and Service Provider Comparisons on Factors Related to Cultural Competence

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Introduction

One of the core values of the system of care (SOC) philosophy concerns the importance of creating culturally competent agencies, programs and services that can effectively respond to the mental health needs of a diverse population (Stroul & Friedman, 1986). Despite the fact that cultural competence is one of the core values for a SOC, most sites funded by the Comprehensive Community Mental Health Services for Children and Their Families Program (CMHS) find that adherence to this principle remains a challenge. Yet, while recruitment of culturally diverse service providers and administrators may be difficult, it is vitally important to successful service delivery and outcomes (Stroul, Pires, Armstrong & Zaro, 2002). In a study examining implementation of SOC services for 27 sites, Vinson and colleagues (2001) found that operationalizing the principle of cultural competence and translating training into effective practices were especially difficult endeavors. More recently, in a comparison of SOC sites and matched comparison sites, Brannan and colleagues (2002) found additional evidence of the difficulties associated with providing culturally competent services.

Conceptualizations of cultural competence vary. This study utilized a cultural competence model based on the work of the Child and Adolescent Service System Program (CASSP; Cross, Bazron, Dennis & Isaacs, 1989). The CASSP model defines cultural competence in relation to four dimensions: attitude, practice, policy and structure (Mason, 1995). The purpose of this research was to evaluate adherence to the principle of cultural competence among administrators and service providers in funded CMHS SOC sites in North Carolina. Comparisons between administrators and service providers at SOC sites provide information necessary to develop strategies for training and implementing culturally competent practices at both the system and practice levels. According to Isaacs-Shockley et al., (1996), the effectiveness of a SOC program is enhanced by the level of adherence to cultural competence principles, both at the administrative and service delivery levels of the organization. Thus, adherence to this value suggests that it should be integrated into every aspect of service delivery (Mason, Benjamin & Lewis, 1996).

Method

The participants for this research were 94 staff members in the two federally funded CMHS sites in North Carolina. Of the 94 participants, 59 were from the FACES site and 35 were from the SOC-NET site. Within these sites, 40 participants worked in an administrative capacity and 54 were direct service providers. All participants completed either the Administrator or Service Provider form of the Cultural Competence Self-Assessment Questionnaire (CCSAQ; Mason, 1995). Because the CCSAQ is based on the CASSP model, which views cultural competence as a developmental process, the CCSAQ is a tool for evaluating the training needs of individuals working in culturally diverse settings. The CCSAQ consists of 60 items divided across six scales: Knowledge of Communities, Personal Involvement, Resources and Linkages, Staffing, Organizational Policies and Procedures and Reaching Out To Communities. The Service Provider form has an additional scale with 19 items, entitled Service Delivery and Practice. Respondents answered each item based on a 4-point Likert-type scale ranging from 1, *not at all*, or *barely*, to 4, *often*, or *very well*.

According to Mason (1995), the CCSAQ meets criteria for reliability; all scales have been found to yield alpha coefficients of .80 or higher, with the exception of the Personal Involvement scale (with a coefficient average of approximately .60). Although much has been written regarding the content validity of the CCSAQ, the external validity remains to be established.

Results

The data were analyzed by performing multiple *t*-tests for the scales and appropriate subscales of the CCSAQ, comparing the responses of administrators with those of the service providers. For this research, we did not look at the Service Delivery and Practice scale since administrators did not complete this part of the CCSAQ. Table 1 presents the mean scores for each of the scales for the administrators and service providers. Comparisons yielded overall mean scores based on the 4-point Likert-type scale. Because this research was exploratory, a modest alpha level of $p < .10$ was used to determine differences among respondents.

Table 1
Overall Mean Scores for Administrators and Service Providers on the Cultural Competence Self-Assessment Questionnaire (range = 1 – 4)

	Means	
Scale	*Administrators*	*Service Providers*
Knowledge of Communities Scale	2.36	2.53*
Knowledge of Risk Factors Subscale	2.21	2.26
Knowledge of Resources Subscale	2.21	2.50**
Personal Involvement Scale	2.63	2.93**
Resources and Linkages Scale	2.74	2.65
Collaboration Subscale	3.17	2.97
Staffing Scale	2.43	2.40
Representation Subscale	2.39	2.28
Hiring Subscale	2.45	2.23
Organizational Policies and Procedures Scale	2.33	1.96
Reaching Out to Communities Scale	3.18	2.95

*$p < 10$, **$p < .05$

The data comparing the SOC administrators and service providers produced several findings. Service providers scored higher in cultural competence on the Knowledge of Communities scale when compared to administrators. This was primarily due to service providers scoring higher on the Knowledge of Resources Subscale . There were no differences on the Knowledge of Risk Factors Subscale between administrators and service providers. Additionally, service providers scored higher in cultural competence on the Personal Involvement scale when compared to administrators. As shown in Table 1, there were no significant differences between administrators and service providers on the remaining scales.

Compared to evaluating administrators and direct service staff, evaluating the overall cultural competence of the staff of the North Carolina CMHS funded sites is more challenging. Since there is as yet no normative data for the CCSAQ, we decided to compare the mean scores to a 2.5 cut-off criteria (the mid-point of the 4 point scale) and a more stringent 3.0 cut-off criteria. Using the 2.5 criteria, administrators were found to be culturally competent for four of the possible eleven scales or subscales of the CCSAQ, and the service providers to be culturally competent for six of the possible eleven scales or subscales. Using the more stringent 3-point criteria, we found administrators to be culturally competent for two of the possible comparisons: the Collaboration subscale of the Resources and Linkages scale and the Reaching Out to Communities scale. Service providers did not meet this 3-point criteria for any of the various categories within the scales.

Discussion

Comparisons of the data from the administrators and service providers revealed that service providers were more culturally competent on the Knowledge of Communities Scale due to their increased knowledge of community resources, and rated as more culturally competent on the Personal Involvement Scale in relationship to the families they serve. Both of these findings were expected and were consistent with the duties required of service providers.

We offer three suggestions for future research in the area of cultural competence. First, future research should focus on developing a consistent theoretical model of cultural competence. Both Hernandez and Hodges (2001) and Weiss (1995) have suggested that successful program change is more likely to occur when theoretical perspectives and theories of change have first been developed. Second, researchers in the area of assessment of cultural competence should focus on developing a universally accepted measure of cultural competence; normative data needs to be established for this instrument. Third, in agreement with Brannan and colleagues (2002), the recruitment of staff who reflect the cultural make-up of the families being served by an SOC is an important aspect of culturally competent service delivery.

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Development of Clinical Guidelines for Rating the CAFAS with First Nations Children and Youth

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Introduction

The Ontario ministries responsible for the delivery of mental health services to children have instituted a measurement initiative that will oversee the systematic measurement of morbidity (at intake) and functional outcomes for all children ages 6-to-17 years of age who receive mental health services in one of 108 organizations situated throughout the province. Outcomes are being measured with the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000). In addition to providing oversight for reliability training and implementation support for the CAFAS tool, our team at the Hospital for Sick Children has undertaken several projects intended to develop clinical application of the CAFAS and to build capacity for the adoption of outcome measurement and other evidence-based practices. This summary reports on one such project: the development of supplemental clinical guidelines to support the rating of CAFAS with First Nation's children and youth.

These clinical guidelines are intended to improve the collection of valid and reliable mental health outcome data for First Nation's children and youth. This is important for at least two reasons. First, we have no systematic standardized knowledge of the mental health problems of Aboriginal children and youth in Ontario. The collection of CAFAS data for Aboriginal children served in the mental health sector will give us the first view of their level of functioning before and after treatment. Second, this data will inform service delivery for this population with very complex and hard to meet mental health needs. Service providers will be better able to advocate for the needs of their Aboriginal clients on the basis of the story the CAFAS data will tell.

Improved services are critical in light of the mental health burden experienced by Aboriginal children. It is estimated that approximately 100,000 children seek mental health services annually in Ontario but it is not known how many of these children are Aboriginal . The estimated prevalence of mental health disorders among Ontario children 4-to-16 years of age was 18.1% in 1983 (Boyle, 1991). Although large-scale survey data are not available in Ontario for comparing Aboriginal and non-Aboriginal children on levels of mental health problems, enough evidence exists to indicate that Aboriginal children are at far greater risk for morbidity than any other child population in the province (Boyle, 1991). Census data indicate that there were 41,395 Aboriginal children in the 5-to-19 year age group in Ontario in 1996 (Statistics Canada, 1996). From this data, we can estimate further that, at a minimum, 7,451 Aboriginal children experience mental health disorders. Further, data from the Ontario Child Health Study report that only about one-fifth of all Ontario children who require mental health services actually receive them. Yet aboriginal people have less access to health care services than other Canadians because of geographic isolation and a shortage of personnel trained to meet the needs of the native population (Moffatt, 1987; Postl, Irvine, MacDonald, & Moffatt, 1994). Approximately 30% to 50% of Aboriginal communities are located in remote regions, and many are accessible only by air (Postl, Irvine, MacDonald, & Moffatt, 1994).

About the Measure

The CAFAS is a clinician-rated measure of functional impairment in children and youth 6 to 17 years of age. It contains a "menu" of behaviorally-oriented descriptions divided into eight subscales: School/Work, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behavior, Substance Use, and Thinking Problems. Scores are also generated for the youth's caregiver on two scales: Material Needs and Family/Social Support. For each scale, the clinician determines the severity level (e.g., severe, moderate, mild, minimal) that best describes the youth's level of dysfunction for the time

period specified (e.g., within the last month). For each scale and each severity level, there are sets of items describing behavior. The levels of dysfunction are assigned values for the purposes of generating quantitative scores. There are no cut-off scores but rather a general framework derived from research with the CAFAS (Hodges et al. 1997; Hodges & Wong, 1996).

Although the CAFAS is not a norm-based tool, caution is nevertheless required when applying it to Aboriginal populations. In an attempt to demonstrate validity for use with a diverse population, Hodges and Wong (1996) reported that, using strict criteria, no significant differences in CAFAS were found across gender, racial/ethnic, or caregiver education level groupings. Although this speaks to the comparability of CAFAS scores, it does not provide sufficient evidence to conclude that the scale holds equivalent meaning across groups. Notably, feedback from Ontario service providers suggests that special consideration is required in rating and interpreting the CAFAS with Aboriginal populations. This insight was brought to our attention by mental health practitioners at Dilico Ojibway Child and Family Services in Thunder Bay, who provide mental health services to First Nations children and families in a non-mainstream, culturally appropriate manner. Seeking to use the CAFAS to generate important aggregate data on the functional status of their Aboriginal clients, Dilico partnered with us in this exercise to culturally sensitize the CAFAS for use with this population.

Method

The first step in developing the rating guidelines was to distribute a survey of the CAFAS items to a selected group of children's mental health service provider organizations across Ontario known to service Aboriginal children and youth. The survey asked respondents to describe any concerns or issues they had with the CAFAS items in the context of Aboriginal clients. Comments were collated and reviewed in consultation with our Dilico partners and an Item Rating Guide was developed. This spring (2004), organizations participating in the measurement initiative will receive the guidelines. Feedback from clinicians will be used to determine the impact of the guidelines on clinical practice, and comments will be incorporated into subsequent versions of the guide.

Results

In addition to providing a brief history of Aboriginal peoples in Canada and the impact of colonization, the Supplemental Rating Guide reviews some of the mental health issues currently affecting Aboriginal children and their families (e.g., substance abuse, poverty, racism, residential school syndrome), and discusses the importance of cultural competence. Three client vignettes developed by clinicians from Dilico Ojibway Child and Youth Services follow the item guidelines. Lastly, the guideline includes a feedback form that seeks further input from service providers and solicits an evaluation of its clinical impact. Special rating considerations for the CAFAS domains are listed below.

Special Rating Considerations for the CAFAS Domains

School Functioning. In rating school functioning, complexities arise depending on whether the child attends a community school (usually away from home) or a reserve (reservation) school, where expectations for behavior and achievement may differ. Clinicians may or may not be aware of the potential impact of these two different schooling environments on the child's functioning. Also, issues of language (i.e., when English is not the child's first language), racism, geography, and victimization are important considerations in rating school functioning. Rating instructions stress that behavior is to be rated as it has been observed or reported. Important issues that place these behaviors in context can and should be elaborated upon in the CAFAS or client assessment report.

Home Functioning. Questions arise in rating dysfunctional behaviors that are believed to be the norm for the family—for example, "frequent use of profanity," "doesn't comply with rules"—and clinicians are left to determine how to rate these behaviors. Raters should consider that the parent is not likely to report this behavior as problematic if they perceive that it is "normal" in the family. In cases like this,

the behavior is not rated. However, if the parent(s) reports that this behavior is typical of all the children in the family, then it should be rated as moderately problematic. The associated goals would focus on helping the client become more compliant in the home context.

Substance Use. Inhaling of gas, glue, and other solvents should always be rated as severe because of the possibility of permanent brain damage or death. While having only "tried" substances is typically rated as minimally dysfunctional, having "tried" solvents should be rated severe.

Thinking. In Ojibway culture, grief reaction may be associated with seeing visions/hearing things. Clinicians with little experience in Aboriginal culture may rate this as psychotic behavior. In some Native communities, hallucinations may reflect multigenerational transfer of life experiences, practices, ceremonies, and superstitions; they are not necessarily psychotic in nature.

Caregiver Material Needs. Many clinicians are concerned with rating real problems in housing as functional difficulties experienced by parents because they may be perceived as "parent-blaming." Problems with housing (e.g., over-crowding), toxic mold, sanitation, and water are very real issues in many Native communities. However, they are not the responsibility of individual families; rather, they represent population-based issues at the Federal and Provincial levels of government. In order to capture the extent of these problems, and their impact on family and individual functioning, they need to be captured in the CAFAS rating.

Conclusion

A publication grant has enabled us to print 200 copies of the *Culturally Competent Evaluation: Clinical Considerations for Rating the Child and Adolescent Functional Assessment Scale (CAFAS) with Aboriginal Children and Youth* (Barwick, Schmidt, & Hodges, 2004) to be disseminated to all Ontario organizations participating in the measurement initiative. We will be seeking feedback on the content and clinical relevance for mental health practitioners working with Aboriginal children and youth. A PDF version of the document is available on-line at http://www.cafasinontario.ca/html/downloads.htm. This version of the guideline represents the early stages of this initiative, and it is expected that feedback received from practitioners will be incorporated into subsequent revisions and re-distributed. We are also interested in determining the extent to which the Supplemental Guidelines are useful for clinical practice with First Nation children, youth, and families.

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Provider/Client Assessment Congruence and Service Access

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Introduction

Youth with substance and/or psychiatric disorders are largely underserved, with only 1% to 13% receiving treatment for either substance abuse or mental health problems (Angold, et al., 2002; Burns, et al., 1997), and less than 30% with diagnosable need ever receiving treatment (US Department of Health and Human Services, 1999). Children and youth from racial/ethnic minority groups are even less likely to receive treatment. Service use among American Indian youth of different tribes varies from 17% to 24% (Novins, Duclos, Martin, Jewitt, & Manson, 1999).

However, access to services requires problem recognition, and many adolescents who have clusters of symptoms that are severe enough to be distressing or disabling may not meet diagnostic criteria (Stiffman, Chen, Elze, Dore, & Cheng, 1997). Therefore, youth may not receive services for substance abuse and mental health problems because providers do not identify them as being in need of treatment. Further, comorbidity, functional impairments, and risk factors also influence identification of need (Caron & Rutter, 1991; Costello, Burns, Angold, & Leaf, 1993; Puura, et al., 1998). This paper presents results of a study that identified the extent to which provider reports of youth symptoms and functioning corresponded with youth self-reports of symptoms and functioning.

Methods

Data for this study were gleaned from a five year, ongoing longitudinal study, The American Indian Multisector Help Inquiry (AIM-HI), which measured symptoms, functioning, and services received in a sample of 401 southwestern urban and peri-urban reservation American Indian teens. Structured interviews were conducted with youth aged 13-20 who were recruited through school and tribal records. Six hundred youth completed a brief screening questionnaire and 150 from the reservation and 150 from the urban area were randomly selected to complete a structured interview. An additional 50 youth whose screening scores exceeded a clinical cut off point from each area were selected to enrich the sample. The sample was weighted to correct for this over-selection of high need youth.

Youth also identified those who helped them with their substance abuse and mental health problems, and these providers were also interviewed. Youth and their providers formed 198 pairs or dyads for the analyses below. Providers—both formal (e.g., counselors, teachers) and informal (e.g., parents, tribal elders)—were asked to rate youth problem severity and presenting problems in the areas of alcohol abuse, substance abuse, violence-related symptoms, behavior problems, depression and suicidality.

Measures

Youth symptoms of conduct disorder, substance abuse or dependence (including alcohol, inhalants, marijuana, or any drug identified by the youth), depression and anxiety, and post-traumatic stress were identified with the Diagnostic Interview Schedule (DIS-IV; Robins & Helzer, 1994). Youth functioning was measured with the World Health Organization Disability Assessment Schedule II (WHO-DAS II; WHO, 1999). Service use is a count of 20 different services recommended, referred to, or provided, taken from the provider survey (M = 4.05, SD = 4.15).

Analysis

"Congruence" was the term used to refer to the degree of agreement between provider and youth on youth need for services (Jones, Badger, Ficken, Leeper, & Anderson, 1987). Congruence occurred if the provider noticed the same symptoms and functioning that were identified by the youth in the research interview. Congruence was calculated as the proportion of matches between a provider and youth on each condition measured, with 0 and 1 representing *no match on any condition*, and *a complete match between all conditions the youth reported and all the provider reported*, respectively.

Tobit analysis was used to account for censoring and skew in the service access variable (Tobin, 1958). The Tobit analysis creates a family of density functions to model a latent variable "propensity to have service access" from negative numbers through zero, and then recreates the existing distribution of the variable from zero into positive numbers. This creates a reference model, showing the standard deviation and the log likelihood. This log likelihood is compared to the log likelihood for the model being tested with the addition of the predictive value of independent variables. This allows the calculation of a goodness of fit statistic by taking the difference between these log likelihoods and multiplying by -2. The value of the goodness of fit statistic approximates a chi-square distribution (Norman & Streiner, 2000), and can be looked up in a chi-square distribution table. In addition, Cox and Snell's (as cited in Nagelkerke, 1991) multiple correlation coefficient can be calculated, using the equation supplied by Nagelkerke (1991), which reduces to $1\text{-}e^{(-X2/n)}$. In this analysis, the reference model showed a log likelihood of -206.869. The intercept value with one degree of freedom is 2.59 (*se* = .66) for a chi-square value of $p < .0001$. The scale value was 5.86 (*se* = .56).

Once the reference model is calculated, the independent variable is added to determine whether it improves the fit of the model, resulting in a determination of whether the probabilistic model computed fits the actual data points better than chance.

Results and Discussion

Symptoms

Providers and youth agreed between 4% and 25% of the time, with post-traumatic and suicidality symptoms the poorest match, and conduct disorder and depression matched about one in four times (see Table 1). Alcohol was recognized by providers for one in 10 youth, and substance problems for almost one in five youth. Functioning was congruent from one percent to 14%. Providers were most likely to notice youth problems in School/work functioning, but even then they missed six out of seven teens with school difficulties.

On average, youth reported more than five symptoms of drug abuse, more than four of depression, and more than three of conduct disorder. Conduct disorder diagnostic criteria were reached for 24% of the youth, depression criteria for 20 % of the youth, 17%

Table 1
Congruence by Type of Provider for Mental Health, Substance Abuse and Functioning Problems (*N* = 198)

Category	*Overall matched frequencies (percentage)*	*Yule's Y Concordance*
Symptoms		
Depression	47 (24)	.25
Conduct disorder	50 (25)	.15
Post-traumatic symptoms	7 (4)	.05
Suicidality	10 (5)	.16
Alcohol problems	22 (11)	.29
Substance problems	31 (16)	.36
Functioning		
Understanding and communicating	26 (13)	.06
Getting around	13 (7)	.24
Self-Care	1 (1)	.14
Getting along with people	16 (8)	-.11
Life activities	28 (14)	.01
Participation in society	18 (9)	.02

Table shows the Yule's Y calculation of concordance, and shows the calculation of matched categories, where if the provider said there was at least a minimal problem and the youth reached diagnostic criteria OR had 2 or more symptoms in the area (except substance as noted), then it was counted as a match.

for substance dependence, and 8% for alcohol dependence. Youth also reported an average of three trauma symptoms, and 47% met diagnostic criteria for one or more disorders. Overall, youth symptoms ranged from 0–86, with a total mean of 18 symptoms across mental health and substance problems.

Access to Services

Service access and positive congruence were correlated at .28 (p = .01). Since positive congruence was a ratio of provider recognition over youth problems, symptoms and functioning did not need to be included in the model. Many individuals had no services for a score of zero. This created a data problem, requiring a Tobit analysis. When positive congruence is at one, meaning a complete match between provider problems recognized and youth problems endorsed, analysis will indicate that the youth will receive a little more than five services. Since this is about the size of a standard deviation from the mean, the whole distribution moves over with the addition of positive congruence, such that the mean is approximately five. The congruence predicts about eight percent of the variance in access, a very small amount since need is presumed to drive services, and the Andersen model commonly measures need as objectively determined from provider report (Andersen & Newman, 1973). This analysis, including the hand-calculated chi-square and multiple regression coefficient, is reported in Table 2. Inside the table is the Wald chi-square of 7.37. This tests the same hypothesis as does the likelihood ratio chi-square that was computed by hand.

Table 2
Tobit Model of Positive Congruence and Symptoms on Service Access

n	*Noncensored Values*	*Censored Values*	*Log Likelihood*	X^2	*df*	*p<*	R^2
85	58	27	-203.239	7.26	1	.01	.08

	df	*Estimate (B)*	*se*	X^2	*p=*
Intercept	1	.47	1.15	.17	.68
Positive Congruence	1	5.55	2.04	7.37	.006
Scale	1	5.38	.54		

Although there is no set standard for evaluating kappa statistics, a kappa of .40 would be said to be moderate at best. Studies of recognition of behavioral health problems show a great deal of variation in the accuracy of professionals. This study included a wide range of providers, some with little knowledge of the youth and training in assessment, and others with a great deal of knowledge about the youth, but little training in problem recognition. We might therefore expect this marginal level of agreement.

For the Tobit analysis test of service access, we excluded areas in which youth and providers were congruent that there was no need for service, since if there is no need there does not need to be access. The modal score for this proportion for problem areas was 0, the median .33 and the mean .40 (i.e., 40% of problems endorsed by youth were endorsed as youth problems by the providers) with a standard deviation of .32.

Conclusion

In this study congruence between providers and youth was moderate at best. Uniquely, we asked youth to name who had helped them; their utility to the youth can therefore not be dismissed. These providers varied from mothers to specialty care practitioners; people with no training on assessment, to those who had a lot of training. Diagnostic difficulties would have been more easily picked up by the specialty care providers; functioning across settings by parents.

Since providers can either expedite, or be a barrier to access, their role in ensuring access includes assessing youth need. When need has been accurately identified, specific interventions can be provided. In the primary care sector, a physician's lack of awareness or detection, and thus lack of congruence, leads directly to lack of treatment (Ormel, Koeter, van den Brink, & van de Willige, 1991). When health services require gatekeepers (as opposed to fee-for-services) to access care, a lack of detection or congruence suggests that the client may not have access to the service (Wells, Hays, Burnam, Rogers, Greenfield, & Ware, 1989). This study shows that congruence between the youth identified problems and provider assessment of their problems can increase youth access to care. The addition of screeners as a part of regular periodic health assessments by primary care physicians, school nurses or social workers, would improve problem recognition and therefore congruence.

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Suicide Attempts and Service Use Among American Indian Adolescents

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Introduction

American Indian youth commit suicide at rates 2-3 times higher than average for other youth (Indian Health Service, 2000), and studies indicate that 15% to 30% of American Indian youth have attempted suicide (Blum, Harmon, Harris, Bergeisen, & Resnick, 1992; Borowsky, Resnick, Ireland, & Blum, 1999; Grossman, Milligan, & Deyo, 1991; Howard-Pitney, LaFromboise, Basil, September, & Johnson, 1992). Despite these elevated rates of suicidal behavior, little is known about rates and predictors of service use among American Indian youth who have attempted suicide. Such information is especially important for prevention efforts, because individuals with a history of attempted suicide are at much greater risk of dying by suicide (Harris & Barraclough, 1997).

The present study explores: (a) how many American Indian adolescents (ages 12-19) with a history of attempted suicide received specialty or non-specialty professional mental health services (lifetime and 12-month rates); (b) how rates of formal and informal service use compare between individuals with, and individuals without, a prior suicide attempt; and (c) whether a suicide attempt history predicts 12-month professional service use, when controlling for mental disorder, substance abuse, and other potential confounders.

Methods

Data are from the American Indian Multisector Help Inquiry (AIM-HI), a 5-year longitudinal study of service use and drug-use patterns among 401 American Indian adolescents in a southwestern state. The current analysis uses data collected in 2001, the study's first year.

In 2001, trained staff briefly screened almost 600 randomly selected American Indian adolescents living in a southwestern state; half lived on a reservation, and the other half lived in a large city almost 20 miles away. From each group, about 150 urban youth and about 150 reservation youth were randomly selected, and the sample was enriched with an additional 50 youth from each site whose scores on the Achenbach Youth Self Report (YSR; Achenbach, 1991) and the Columbia Impairment Scale (CIS; Bird, et al., 1993) indicated a likely need for services.

To assess a history of attempted suicide, each adolescent was asked, "Did you ever try to end your own life (whether or not you thought about it ahead)?" Interviewers used portions of the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981) to measure depression, conduct disorder, and alcohol and drug abuse or dependence. Service use was measured with the Service Assessment for Children and Adolescents (SACA; Stiffman et al., 2000). Using log-linear chi-square analysis, bivariate relationships were examined between suicide attempt history and the following five different types of service use (12-month and lifetime) for behavioral or mental-health problems:

1. Specialty mental health professional (e.g., psychiatric hospital, drug treatment or mental health clinic, residential treatment, partial hospitalization, or mental health professional such as psychiatrist or psychologist)
2. Non-specialist professional (e.g., teacher, pediatrician, probation officer, clergy, emergency room, group home, child protective service)
3. Informal adult (parent, grandparent, other relative, friend of parent, other respected adult)
4. Peer (friend or friends same age as respondent)

5. Traditional (shaman, spiritualist, medicine man or woman, sweat lodge leader, talking circle, or spirit running group).

Logistic regression analyses were performed to determine whether a suicide attempt history predicted professional service use in models including mental and substance use disorders, physical or sexual abuse, cultural identity, and social support, as well as gender, location, and income. Because one-quarter of the youth were purposively included in the study, all data analyses were weighted to preserve the generalizability of results to the random sample. STATA (STATA Corp., 2003) was used for all statistical analyses.

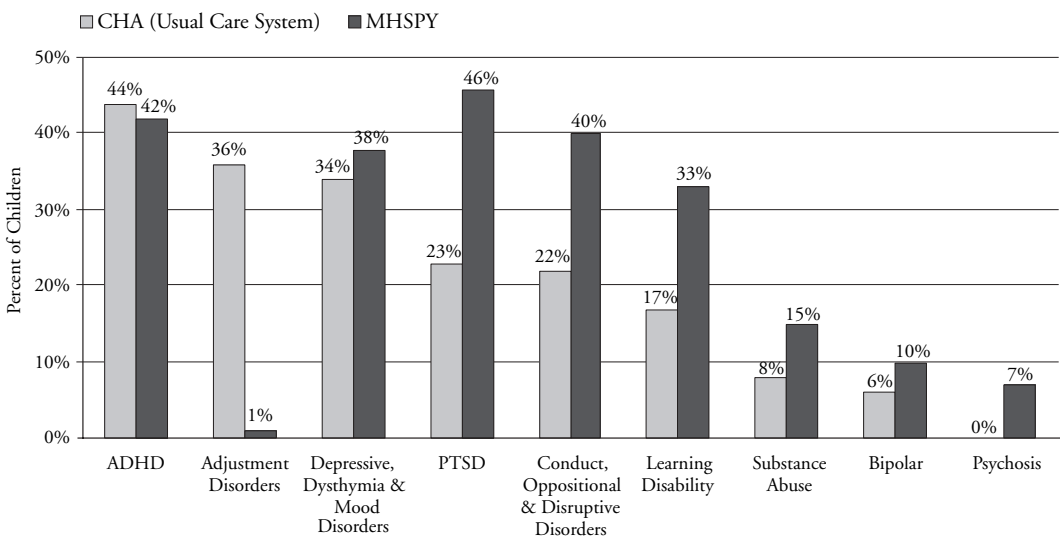
Results

This sample of urban and reservation American Indian youth had high rates of suicidal ideation and suicide attempts (26.4% and 16.5%, respectively). Generally equal numbers of reservation and urban youth had attempted suicide (17.0 % vs. 15.4%, reservation and urban.), but reservation youth had higher rates of suicidal ideation (30.9% vs. 21.8%), $\chi^2(1, N = 401) = 4.2$, $p < .05$.

Fewer than 1 in 4 attempters received specialty mental health services in the previous year (see Figure 1). Twenty-two percent of suicide attempters in the sample received specialty mental health services in the previous 12 months, compared to 6.8% of non-attempters, $\chi^2(1, N = 401) = 14.2$, $p < .001$. Overall, 39.9% of suicide attempters ever in their life received specialty mental health services, compared to 16.0% of non-attempters, $\chi^2(1, N = 400) = 18.9$, $p < .0001$.

Instead of seeking specialty mental health services, adolescents more often sought service for mental health or substance abuse problems in non-specialty professional settings, such as school, foster care and juvenile justice systems. In the prior year, 42.3% of suicide attempters received such services from

Figure 1
Comparison of the Frequency and Distribution of Diagnosis
Among CHA System Recipients and MHSPY Enrollees



C.H.A. System – $N = 87$
MHSPY – N=100
Diagnoses unique to each system that are present in less than or equal to 3 children include:

- C.H.A. System: Obsessive Compulsive Disorder, Eating Disorders, Paranoid Schizophrenia, PDD, Anxiety Disorder, Separation Axiety, Mental Retardation, Reactive Attachment, Borderline Personality Disorder.
- MA-MHSPY: Obsessive Compulsive Disorder, Child Sexual Abuse, Anxiety Disorder, Asperger's, Agoraphobia, Mild MR, Separation Disorder, Panic Disorder, Selective Mutism, Seizures, Reactive Attachement Disorder, PDD, Tourette's Syndrome and Autism.

professionals outside the specialty mental health field, compared to 27.0% of non-attempters, $\chi^2(1, N = 401) = 6.4$, $p < .05$. Lifetime service use in non-specialty professional settings was 65.5% among suicide attempters and 44.6% among non-attempters, $\chi^2(1, N = 401) = 9.7$, $p < .01$.

The most popular sources of help in the previous year for mental-health or behavioral problems were informal adults (e.g., relatives, parents' friends, elders) and same-age peers. In the prior 12 months, 62.0% of suicide attempters and 49.0% of non-attempters received help from an adult they knew informally, $\chi^2(1, N = 401) = 3.7$, $p = .05$. Fifty percent of both attempters and non-attempters were helped by a peer in the previous year.

A traditional healer, such as a shaman or medicine man, provided help to 15.5 % of suicide attempters in the previous 12 months, almost double the rate (7.9 %) for non-attempters, $\chi^2(1, N = 401) = 3.7$, $p = .05$.

No significant differences existed between reservation and urban suicide attempters' use of non-specialist professionals, informal adult helpers, peers, or traditional healers in the previous 12 months or ever. However, significantly more reservation than urban youth reporting a suicide attempt received specialty mental health professional services in the prior year (34.1% vs. 7.8%), $\chi^2(1, N = 401) = 5.0$, $p < .05$.

Despite the strong bivariate relationships with a suicide attempt history and 12-month professional service use, a suicide attempt was not a significant predictor when including psychosocial variables and other potential confounders in a logistic regression model (see Table 1). Instead, significant predictors for both specialty and non-specialty 12-month mental health service use were depression and substance abuse or dependence. Additionally, living on a reservation was a significant predictor of specialty mental health service use within the previous year.

Weighting the data only trivially changed the results in all analyses, suggesting that receipt of services does not differ among randomly selected youth and youth purposely selected because of their high needs.

Table 1
Predictors of 12-Month Specialty and Non-Specialty Mental Health Service Use (*N* = 401)

	Specialty Mental Health		*Non-Specialty Mental Health*	
Variable	*Odds Ratio*	*95% Confidence Interval*	*Odds Ratio*	*95% Confidence Interval*
Depression	3.8	1.7 – 8.3	2.3	1.3 – 4.0
Substance abuse or dependence	3.1	1.5 – 6.4	2.2	1.3 – 3.6
Reservation resident	2.5	1.1 – 5.6	NS	–

Discussion

Although suicidal behavior is a serious problem, relatively few American Indian adolescents with a suicide attempt history received specialty or non-specialty professional mental health services. Fewer than 1 in 4 used a specialty mental health service in the previous year, and less than half did so ever in their life. Service use rates were higher in professional settings outside the specialty mental health sector, but still fewer than half of suicide attempters received such services in the previous year. Furthermore, although suicide attempters had higher rates of all types of professional service use than non-attempters, a suicide attempt history did not significantly predict receipt of specialty or non-specialty mental health services in multivariate analyses.

The data have several limitations. The lifetime measurement of attempted suicide makes it impossible to know whether youth with a suicide attempt history sought help before or after the attempt. It is also unknown whether the youth received help specifically for their suicidal crisis or for other reasons. Nevertheless, the rates illuminate the point that many suicide attempters have never in their life received any type of professional help for emotional or behavioral problems.

This study can help inform prevention and research efforts. The findings indicate that more research is needed into why low numbers of American Indian suicide attempters received professional services—and how to reach those who forego such help. At the same time, the high rates of help-seeking from informal adults and peers suggest that most American Indian adolescents, whether or not they have attempted suicide, do actively seek help from the people they see most: friends, family, and family friends. This finding suggests that more education about suicide prevention and intervention needs to be directed toward informal helpers.

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Brief Symposium

Social, Cultural, and Economic Factors Impacting the Well-Being of Children and Families in Chile, Colombia and Mexico

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Symposium Introduction

Ricardo Contreras

This symposium discusses findings from research, evaluation and demonstration projects that address current issues with children, families and communities in Latin America. The papers examine some of the structural social, cultural, and economic conditions that serve as a context for people's daily lives, as well as some of the community-level manifestations of those structural conditions. The perspectives offered by these researchers are linked to their national and global contexts and provide a wider lens for the examination of issues that affect children and families cross-nationally and in the United States. Authors of the first paper discuss the impact of social capital on the out-migration of indigenous people from Hidalgo, Mexico to Clearwater, Florida. Authors of the second paper discuss the research component of a program that works to eliminate extreme poverty in Tamaulipas, Mexico. The third paper addresses the need for emergency response to social, economic, and physical needs in Colombian communities affected by man-made and natural disasters. The fourth paper addresses the changing roles of mothers and fathers in Chile, and the final paper presents findings from a study that examined changing social and academic needs of adolescents in high school in Tamaulipas, Mexico. The presentations provide unique perspectives, tools and philosophical approaches that can enrich the repertoire of systems-of-care research and practice.

Building Transnational Communities: The Hidalgo-Clearwater Connection

Maria Crummett & Ella Schmidt

Introduction

This paper examines the impact of Mexico–U.S. migration on civic participation in both home and host communities. Focusing on migration between Ixmiquilpan, Hidalgo and Clearwater, Florida, this research represents an effort to understand the ways in which transnational communities emerge, flourish, and transform civic life including local economies, governments, and cultures on both sides of the Mexico-U.S. border.

Located in the Mezquital Valley of the state of Hidalgo, Ixmiquilpan is home to a large indigenous population, the Hñahñu (Otomí), who have a long history of struggle for ethnic and cultural survival that dates to pre-Colombian times. Dismissed by some scholars and members of the Mexican elite as having been "invented" by the federal government's *Instituto Nacional Indigenista* (National Indigenous Institute), the Hñahñu illustrate a powerful instance of reappropriation of cultural symbols and social and cultural space.

Strategy

Over the past ten years, over 10,000 residents of Ixmiquilpan have migrated to Clearwater to work in the economy's service sector (e.g., hotels, restaurants, construction, and lawn maintenance). The exodus of residents from downtown Clearwater in the 1970s, in which one-third of business and residential spaces were vacated, the explosive growth of the hotel and related tourist industries in the mid-1980s, and the need for a low-wage, reliable and flexible labor force created a favorable environment for Mexican migrants. Thus, from a trickle in the mid-1980s to a steady flow in the 1990s that now represents over 10% of Clearwater's population, Mexican migrants are injecting new economic and cultural life into the city. No longer perceived as marginal residents, migrants in Clearwater are opening small businesses such as groceries, bakeries, restaurants, music stores, and money wiring establishments that not only cater to the Mexican migrant community but also serve as sources for employment for recent immigrants.

Remittances from the United States are one of the most important economic consequences for Mexico. In May 2002, migrants sent over $921 million dollars to family members in Mexico. Estimates of remittances from Clearwater to Ixmiquilpan range from $1.5 to 2 million dollars per month. These remittances are changing the face of Ixmiquilpan as migrants contribute to regional economic development through the construction of homes, roads, schools, county buildings, and small businesses. Many of these constructions, replicas of designs found in the United States, have contributed to an unprecedented transformation of Hidalgo's physical, social, and cultural environment. Numerous rural development programs have also emerged with the growth of remittance income including the development of eco-tourism and cooperative-based handicrafts industries (e.g., textiles, wood carvings, shampoos, lotions, and sponges) managed through traditional community organizational principles.

Methods

The research methodology for this study includes: (a) a review of 1990 and 2000 census data on population and demographic changes in Hidalgo, Mexico and Clearwater, Florida; (b) a literature review of migration case studies on economic integration and civic participation of other Mexican migrant communities in the United States; and (c) in-depth interviews with key informants in Hidalgo and Clearwater that include community leaders, government officials, representatives of civic and religious organizations, and small business owners.

Results

The nature and extent of the migratory process between Ixmiquilpan and Clearwater has led to the development of strong linkages that transcend national borders. Since 2000, for example, representatives from the Hidalgo state government, including the Office in Support of the Hidalgo Community in the State and Abroad, the Secretary of Public Works, and the president of the Commission on International Migration of the Legislature, have visited Clearwater on a regular basis to address migrant issues with city officials, the police department, immigration organizations, and social service and religious groups. Clearwater city officials have also traveled to Mexico to meet with their governmental counterparts in Hidalgo. Numerous civic and ethnic organizations, in place before mass out-migration from Hidalgo, have become transnational in character. These organizations maintain a base of support and communication linking the Hñahñu communities in Ixmiquilpan with those in Clearwater.

Conclusion

This research goes beyond traditional economic analyses that focus on push (problems of poverty and lack of opportunities in Mexico) and pull (labor demand in the United States) forces to explain population movements across international borders. Rather, the project places economic processes within a cultural context where civic expectations and participation are based on a strong sense of community present in both the sending and receiving communities. In short, this research focuses on

how community traditions and civic responsibility craft themselves into migrants' economic, social, and cultural strategies for survival.

Looking our Children in the Eyes: Combating Extreme Poverty inTamaulipas, Mexico—Project 40

Jorge Trujillo Bautisa

Introduction

Project 40 is a program implemented in the State of Tamaulipas to improve the well-being of low-income families. The project is led by the *Sistema para el Desarrollo Integral de la Familia,* or System for the Integral Development of Families (DIF). Other governmental secretariats participating in the program are from the offices of Economic Development and Employment, General Government, Social Development, Health, Urban Development and Ecology, and Education, Culture and Sports. Together the secretariats are engaged in a full battle against the extreme poverty conditions that prevail in 40 rural communities throughout 20 municipalities of the State.

The State of Tamaulipas is located in the northeast region of Mexico along the Gulf of Mexico coastline. Almost one-third (32.6%) of its population lives under the line of extreme poverty, including 42.4% living in overcrowded housing. Almost one-fourth (23.5%) of those residents over 15 years of age have not completed elementary education, and nearly one-half (46.7%) of the labor force has an income level of no more than twice the minimum wage ($6.00 a day).

Strategy

The goal of Project 40 is for projects to emerge through the community's own initiative and to receive support from State government and private organizations. Families implement these projects in each community. Project 40 combats poverty through three fundamental branches of government that include Social Assistance and Infrastructure, Nutritional Security and Training of the Labor Force. The Social Assistance and Infrastructure Branch aims to improve the infrastructure of communities through setting up power, water and sewage lines and assisting with construction of additional rooms in dwellings to deal with overcrowded living situations. The social assistance aspect of this branch includes looking after medical needs of the community through the institution of community health committees, which function as outreach mechanisms to distribute medicines and refer patients to hospitals in each area. Medical examinations are also conducted to diagnose malnutrition in children and prescribe dietary care. Committees distribute groceries and recipes to improve the population's general dietary habits.

The Nutritional Security branch works to provide the necessary means for families to have food on the table every day. Communities are assisted with technology to produce the staples needed for daily subsistence. This is especially important during the annual drought period between May and August, when families require assistance with basic survival needs. Assistance has included training in the installation of family orchards and rainwater collection systems that provide water for human consumption and orchard irrigation. Families are also provided with animals such as chickens, sheep and goats to diversify farm food sources. Some communities receive supplemental cattle feed to assure survival during the critical drought period.

The Training of the Labor Force branch is made up of two fundamental elements. These elements are geared toward keeping the community's circulating cash from leaving the local economy, and to generate resources to strengthen the families' finances. Activities of this branch include assessing each community's needs for financial training and determining existing economic channels. Training that matches the communities' existing labor interests is conducted during the first few months of the project. Projects are then implemented to increase the productivity of communities and to impact local economic networks as well as networks with other communities. For example, in one community the project assisted with the

acquisition of a grain mill through the backing of the Governor of the State. This mill made it possible for the community to provide its own cattle feed and to sell feed to other communities. In another community, organized groups of women formed micro-businesses, "tortilla factories," to produce tortillas for sale in their neighborhoods and in the larger region.

Methods

Based on specific poverty indicators (CONAPO, 1995; INEGI, 2000), Project 40 selects the most impoverished communities in the state for participation. During the selection process, research is conducted to provide a socioeconomic profile of communities, including the educational level of its workforce and assessment of the families' most pressing needs. The community is also surveyed to map its most cohesive social networks in order to enlist community members' assistance in project promotion and implementation.

Evaluation of Project 40 includes three different tools. A logbook is used for internal evaluation that documents the results of activities and measures these against the original objectives that were delineated by each of the participating institutions. Data from interviews conducted by the Governor and First Lady during their tours of participating communities function as the second tool. These interviews provide information about families' impressions of the results of Project 40 in their communities. An evaluation report issued directly to the DIF president, through a "mobile network" that is part of the internal program of the DIF system, is the third tool.

Results

The project evaluation team found that the most popular technology provided to communities was the rural stove. Unlike traditional methods of cooking, rural stoves have a chimney attached, which reduces the quantity of wood required for cooking and the amount of smoke released into the home. Older women expressed special appreciation of the reduced physical strain due to more economic use of wood, "Before, we cooked the beans with seven firewood sticks and it took three hours and a half to get them ready for the meal and now they are done in one hour and a half and we only need to use three firewood sticks that last us the entire day." Some women also reported the value of reduced effects of smoke on clothing, "Look, the best thing for me is that I don't have to change clothes several times a day due to the smoke stains like in the past, and that is a great thing." Women also noted that the stoves reduced the risk of burns and presented less risk to pregnant women and small children because of reduced smoke inhalation.

Project findings also indicate that Project 40's success in combating poverty among families and children in Tamaulipas has been the result of teamwork. The project's participatory approach to community development has given all participants the satisfaction of being able to look into the eyes of their children, with pride in their accomplishments and an uncompromising resolve to better their childrens' futures.

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Introduction

This work presents the theoretical concept of a biogram as applied to a community setting. The instrument developed based on this concept has been called a sociogram. Sociograms have been used to highlight how attraction, rejection, and preferences are linked within a group, but may also be applied in different ways. Related concepts from sociology and other disciplines such as forecasting and risk analysis have also contributed to the construction and application of the sociogram instrument. Based on the concept of risk analysis, the method for applying the sociogram tool permits categorization of communities at risk by the size and probability of future problems. It not only allows for identification of risks, but also the formulation of short, medium and long term strategies that are agreed upon by the community to reduce its social vulnerability. This process takes place in the domain of preventative intervention to diminish risks.

Social vulnerability identified by the sociogram may be associated with variables related to natural, human or technological threats, making it applicable to several types of risk that affect groups of people. This working tool was applied to a group of 35 communities situated in different districts and boroughs of the city of Medellín that are facing specific threats. The current presentation describes the methodology, instrument, and results obtained from this study.

Specific objectives of the project were to design a practical tool that permits the categorization of communities that are at risk and carry out an experimental application of the instrument. The project also provides technical training in prevention and intervention in disasters as well as in the formation of neighborhood committees. Finally, the project seeks to identify the levels of risk discovered as a result of using the sociogram and to describe the findings from the application of the sociogram in the communities of interest.

The Sociogram

The following is a description of the sociogram model applied in the project entitled, Technical Training in Prevention and Attention to Disasters and the Formation of Neighborhood Committees in Medellín during the First Term of 2002. This model serves as the working background for the components shown in Table 1. The planning process starts with the identification of the community in its physical surroundings. At this point there is a brief description of the recent history of the community, its important sociodemographic characteristics, level of participation, relation to the environment, and economic sustainability. Once the community has been defined, the next task is to compile information about emergencies that have occurred in the past. This allows for a more precise definition of an action plan that will lead to a future-oriented study of threats to be included later in the planning process. The study of threats and dangers includes internal and external phenomena that are then located on a map and incorporated into the plan; this way, there is greater clarity over the possible, probable and imminent dangers as well as their geographic locations.

The next step is to qualitatively assess the threat. In this step the potential for occurrence of an event at a certain level of severity is graded and put into categories that include possible, probable and imminent events. A possible event concerns a phenomenon that may occur and for which there are no

Table 1
Components of Social Vulnerability

Component	*Variable*	*Indicator*
1. Participation	Organizational structure	• Existence, number, character • Characteristics of participation (why, for what, how, by whom) • Leadership (shared, autocratic)
	Decision capacity and action	• Management • Assembling • Agreement
	Collective level of knowledge	• Education • Training content • Experience
2. Relationship with the environment	Social interaction	• Sense of belonging and identity • Communication and information Systems • Population movements
	Security	• Needs satisfied • Systems and norms • Risk and dangers (threats to life and belongings) • Use of public or communal space • Protection and control systems.
3. Economic sustainability	Productive Capacity	• Resources availability • Resources utilization
	Economic structure	• Formal Economy • Informal Economy • Public • Private
	Planning capacity	• Planning process • Implementation • Follow up and control

historic or scientific reasons for it not occurring. The color green is used in the sociogram to signify this level. A probable event entails a phenomenon that is expected and for which there are technical, scientific and preceding reasons and arguments to believe that it will occur. The color orange/yellow is used in the sociogram for this level. An imminent event is a phenomenon that is expected to have a high probability of occurrance and is represented by the color red.

Social vulnerability is determined in the next step. Once the threats are identified and located, the analysis moves forward to the question of how such threats might affect the risk elements identified in the areas of participation, relation to the environment and economic sustainability. Next, a level of vulnerability is determined, which is then incorporated into the future-oriented strategy. The analysis that leads to the identification of a communities' vulnerability includes examination of the nature of the components that form the risk elements (i.e., participation, relationship with the environment and economic sustainability), the variables that are part of these components (i.e., organizational structure, decision capacity, level of knowledge, social interactions, sense of security, economic capacity, economic structure and planning processes), and the specific and measurable manifestations of each of the variables, called indicators.

Table 1 shows these components of social vulnerability including variables and indicators that signify low risk. Each indicator is also described in terms of how it is measured and quantified. For example, the organizational structure variable has indicators labeled *existing organizations*, *leadership* and *type of participation*. To score the vulnerability of each component, each item is given a value of 0 when the

elements included in the definition are *present*, 0.5 when they are *partially present*, and 1 when the components in the definition are *not present*. When these numbers are summed, vulnerability is then assessed as *low* (green) when the results are between 0.3 and 3.0, *medium* (yellow) when results are between 3.5 and 5.5, and *high* (red) when they are between 5.5 - 8.0.

Next, risk is defined in terms of the relationship between risk and vulnerability (Table 2). The level of risk may vary based on the time selected for the analysis. Risk is assessed as high, medium, or low, based on the number of red, yellow, or green components. High risk means that 75% to 100% of the variables that represent vulnerability and threat are at their maximum level. This means that the threat could cause a significant change in society, the economy, the infrastructure and the environment. Medium risk means that 25% to 50% of the values that represent vulnerability are high and that the threat is high or that all

Table 2

Component	*Variable*	*Indicator*	*Time (months)*											
			1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*
Threat														
Type:		Score:												
Social Vulnerability														
Participation	Organizational structure	Existing organizations												
		Leadership												
		Types of participation												
	Capacity for decision making	Management												
		Assembly												
		Agreement/consensus												
	Collective knowledge	Education												
		Training												
	Score													
	Level of Vulnerability													
Relationship with the Environment	Social Interaction	Relationship with the environment												
		Sense of belonging												
		Systems of communication												
		Population Displacement/movement												
	Security	Needs met												
		Systems and norms												
		Risks and dangers												
		Common or public spaces												
	Score													
	Level of Vulnerability													
Sustainable Productivity	Economic structure	Formal Economy												
		Informal Economy												
		Public sector												
		Private sector												
	Productive capacity	Resources availability												
		Use of resources												
	Planning	Planning processes												
		Execution, follow-up, monitoring of plans and projects												
	Score													
	Level of Vulnerability													
Risk														

three of the components are scored as medium. Low risk signifies that 25% to 50% of the values scored for vulnerability and threat are at intermediate levels of risk, or that 70% to 100% of the vulnerability and the threat are controlled for; in this case, it is expected that the social, economic and environmental effects will amount to a lower level of loss in the community.

The final step in the sociogram process is to develop measures of mitigation and risk reduction. Once risks are defined for each threat and each component of social vulnerability is described, all those measures that lead to its reduction are considered and included in a plan for effective risk reduction. This is translated into actions to reduce the threat as a method of prevention in the context of planning for disaster situations. For example, the presence of high and medium risk alerts the community to the need to take measures to reduce risks using interventions focused on vulnerable areas. These interventions are continued until risk is reduced to a tolerable level.

Discussion

The development and application of the sociogram in 35 communities in Medellín, Colombia suggests that different sociograms need to be developed for different threats. This is because each threat may have a different time span over years, months, weeks or days. For example, threats that are natural in origin may require a time span of twelve years while threats of man-made origins may only need to be considered across a time span of twelve months. It was also found that the viability of the strategies that are developed depends less upon the characteristics of the threat than upon agreement that is reached through a participatory process, using the management capabilities and other conditions specific to each community.

The model applied in this project indicated that its use can strengthen the social fabric of communities subject to natural, technological or human threats through the application of a diagnostic tool. This tool permitted the assessment of the level of social vulnerability based on community input and resulted in identification of the most important variables, which contributed to the generation of the vulnerability index. The sociogram was also useful for generating participatory strategies of risk mitigation within different communities.

Strengthening Men's Rights to Participate in the Raising of Their Children

Sabine Romero

Introduction

For more than 30 years, the Center for Education Research and Development (*Centro de Investigación y Desarrollo de la Educación*; CIDE) has been developing and implementing educational programs applied at formal and informal levels, with the objective of improving the quality of life of Chile's underprivileged population. A great deal of this work has focused on families, including their internal dynamics as well as the relationships they establish with other key social players in the education and health environments.

In 1996 a process of fieldwork practices evaluation was initiated by the lead team responsible for programs that intervene in the social-affective and family arenas. The group realized that even though the fieldwork supposedly targeted the family unit, the vast majority of its area of scope tended to focus around the mother in the household.

Along with the idea of improving the impact that the educational interventions could have in the internal dynamics of family relations, other concerns surfaced among the team. For example, the team was concerned about the potential of programs to place even more burden on the woman's motherhood role, expecting her to harness all her skills related to raising children, and to fulfill increasing demands

for involvement in the school and other activities. In this regard, the team was concerned about the equitable distribution of household responsibilities at the core of the family group. Obviously, changes in the division of tasks and chores on the home front have not always matched the demands created by the incorporation of women into the labor market during recent years; the resulting extra workload ends up being placed solely on the woman's shoulders. On many occasions, this produces a very stressful environment for the woman and a strained climate for the rest of the family. This simmering tension is one of the preceding factors for the generation of cycles that contribute to violence in the home.

As a result of these concerns, The Engaged Fatherhood Program was initiated in 1998. Its first phase explored mens' perceptions and their experiences—both satisfactory and difficult—of fatherhood. In the second phase, the program was expanded to explore men's perceptions of the social services personnel who work with families.

The Engaged Fatherhood Program

There is a dearth of adequate settings where men can engage in dialogue with one another about topics related to personal and affective aspects of their lives (Morales & Romero, 2000). This plight limits the fathers' ability to expand their behavioral skill set with respect to child-raising techniques. The possibility of engaging in discourse with others about their parental responsibilities was valued highly by both the trained monitors as well as the fathers who attended the workshops.

Traditional views of fatherhood tend to persist among parents and social service providers (Morales, 2001). For example, group monitors were inclined to perceive families to be social groups that include the child (the main objective of their work) and the mother, frequently leaving the father on the sidelines. Yet the program also corroborated prevalent theoretical observations about the changes that are taking place among younger generations; these changes include a greater respect for shared household responsibilities between mothers and fathers. However, at the behavioral level this attitudinal change was somewhat limited. In practice, the traditional responsibilities for both parents continued to follow along traditional lines, with the resulting isolation of the father from the child-rearing process.

During a third phase, CIDE's team of professionals implemented the program in three Chilean public institutions with substantial coverage of pre-school care: (a) National Board of Pre-Schools (*Junta Nacional de Jardines Infantiles*; JUNJI); (b) National Network of Student Support (*Red Nacional de Apoyo al Estudiante*; JUNAEB), and (c) the INTEGRA Foundation. It was expected that the professional and technical personnel involved would modify their policies and procedures, incorporating the father into their outlook of the family as a relevant component in the educational and formative developmental processes of children. During the year 2002, a group of 116 individuals were trained to work with families. The goal was to spearhead a crucial change in the traditional behavioral patterns associated with parenthood roles by the men and women participating in the program. The following are findings of successes and obstacles encountered in the third and final phase of the Engaged Fatherhood Program.

Results

Successes

The inclusion of Engaged Fatherhood in the training agenda for monitors who work with underprivileged families and children, and those in extreme poverty, was itself a success, as was the promotion of Engaged Fatherhood by directors of institutions. Further alliances with different hierarchical levels of the three institutions were generated, which facilitated the program's viability. Attitudinal changes among training participants related to men's role in child raising, the quality of men's involvement in child raising, and closer bonds to the school system were also noted. Additionally, participants reassessed their prior experiences with regard to their own fathers, and were receptive to becoming better informed and more knowledgeable about the concepts of masculinity and family. Overall, we found evidence of various applications of Engaged Fatherhood's objectives, such as the

development of sensitivity training for fathers and work teams, inclusion of the program in workshops and in agendas for discussion topics in meetings with parents and legal guardians.

Obstacles

However, we also found obstacles to the Engaged Fatherhood Program. For example, the presence of a dominant model of masculinity (and fatherhood) among the parents or legal guardians interfered with the message of the program, resulting in difficulties with gaining the commitment and participation of men. Difficulties with handling intense emotions associated with childhood experiences of fathers were noted. Furthermore, history of conflicts between the school and the legal guardians was also an issue for some participants, along with work overload of the school system that impedes dealing with psychosocial topics and the allocation of time to parents' workshops. Difficulties working with both fathers' schedules and childrens' schedules were also a concern.

Conclusion

Domestic inequities between mothers and fathers in Chile will not be resolved "over night." As seen with this project, even though younger fathers may initially accept the need to relieve mothers of undue burdens associated with child raising and other domestic responsibilities, it is easy for these families to slip back into traditional roles.

The Engaged Fatherhood Program offers encouragement that traditional domestic roles can eventually change. However, as revealed by the obstacles identified in this paper, there is more work to be done. Interestingly, successes of the program were largely attitudinally-based, whereas many obstacles have their roots in external, systematic issues, such as problems with school systems and legal guardians.

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Relationship between the Family and Socio-Academic Performance of High School Students in Tamaulipas, México

Ana Lucia Montemayor Marin & Silvia Vásquez González

Introduction

This exploratory study examined the correlation between social and academic variables for 2,226 high school students in various programs within the State Education System of Tamaulipas. This presentation summarizes results reported in two documents that were produced based on this study. The first document profiles adolescents and their families for the State of Tamaulipas, presenting the correlations between family variables and social and academic performance. The second document is a comprehensive proposal to improve academic and social performance of high school students.

Methods

Two interview tools were implemented in this study; one was given to students to determine their perceptions of their families, and the second queried school teachers to determine perceptions about students and families. Specifically, the second tool aimed to integrate perceptions about students as adolescents and the influence of family characteristics, teacher-student communication, family relationships, rules and lifestyles, and family structure and integration as the nucleus of social interaction.

Several hypotheses guided this study: (a) that there are affective and communicative barriers to the integration of adolescents into the educational setting, (b) that teacher-student communication exerts a more significant influence on school performance than does parent-child communication or social welfare conditions, (c) that the parent's level of education will influence the student's social skills and the organizational characteristics of the family, and (d) that school performance is influenced by family changes in organization, authority, control and role of family members.

The research focused on students as both the subject and object of educational action by examining student perceptions and reactions as well as other qualitative aspects of teacher-student relationships and family dynamics. The degree of association between these variables was measured using a Pearson's contingency correlation coefficient.

Results

Findings from the profile of adolescents included differences in the school performance of students from urban and rural school districts within the state. The geographical, economic and sociocultural characteristics of the families were found to have differential effects. In urban areas there were higher levels of absenteeism, school failure and school dropout. Traits related to academic performance included levels of respect, deference to authority, collaboration and interdependence. More favorable traits were found in rural areas, which were attributed to greater participation in community activities that favor solidarity and which result in satisfactory relationships for adolescents and their families.

Based on these findings, a comprehensive proposal for intervention was developed. This proposal includes six objectives for improving academic and social performance of adolescents, as follows:

- Inclusion of diagnostic elements in schools to determine social or academic problems of students and their families and to prevent problems early in the process,
- Promote group processes among students that allow for individual expression of their potential and to help identify barriers that affect communication,
- Improve group integration in schools so that students become more committed to school and are able to finish,
- Implement an integrated educational service for students,
- Extend services to the community so that there is an educational connection with families, and
- Orient education toward the development of potentials in students who face problems so that they are assisted in making objective choices that further their progress through high school.

Conclusion

Proposed program elements resulting from this study are related to the objectives named above. The first element is the integration of learning groups into schools, with an institutional orientation that would require teacher professional development, integration of groups of excellence, and the development of learning labs. A second element is systematization of diagnosis at the individual, group and social levels, with professional orientation that would consider the social context, level of group commitment to school and social performance. A third element is attention to issues at the personal level, which would include integration of personal development groups, case management, and promotion of services for the well-being of students, based on an individual orientation. Further, an element that gives attention to issues at the family level would include family education and promotion of available services based on a vocational orientation. Last, an element that considers issues at the community level would include changes in institutional management, provision of community wide events such as youth conferences, and links with the economic and governmental sectors and would be based on a socioeconomic orientation.

Symposium Discussion

Ricardo Contreras

The system-of-care philosophy calls for the implementation of mental health services through strategies that place the child and his or her family within a larger community context. The implications of a contextual (or ecological) approach to child mental health services goes far beyond a systemic, community-based, and culturally competent approach to service delivery. This approach also incorporates an understanding of the economic, cultural and political characteristics of the communities and populations served by the system of care. This is particularly true when serving immigrant transnational populations, that is, people who live in-between countries and cultures, or families who are divided by borders and whose members commonly transition between countries. In these cases, understanding the broader context becomes essential in order to build systems of service delivery that truly respond to the needs of target populations.

In this symposium, Crummett and Schmidt discussed an on-going research project about the impact of U.S.–Mexico migration on civic participation along both ends of the migratory circuit. The study focused on the economic, social and cultural strategies of survival that immigrants develop in Clearwater, as well as on the strategies developed by the families that are left behind in Hidalgo. From the point of view of the delivery of mental health services in Clearwater, it is of particular interest to learn about immigrants' social organization in Clearwater, along with immigrants' mental health beliefs, and their traditional approaches to mental health care. A system of care for immigrants that integrates knowledge of these three elements would increase its potential of being culturally competent and of effectively reaching out and treating children and families.

In the second paper, Trujillo presented a program to fight extreme poverty in rural Tamaulipas, Mexico. The project presented in this paper teaches us that in communities living below the poverty line, it is essential to address family and community needs comprehensively. Of course, the availability of resources would shape how comprehensive the approach would have to be. In this case, the state government determined that basic community services, such as health, nutrition, and employment, had to be addressed in order to remove families from conditions of extreme poverty. In societies with greater availability of resources, the approach could include, among other things, building and strengthening a safety net for the unemployed or the ill. Regardless of the level of resources, the Tamaulipas case suggests that the delivery of children's mental health services in communities under the poverty line must be an integral component of a broader strategy aimed at satisfying basic needs. Thus, mental health needs may be satisfied, just as basic needs are satisfied, and not independently.

Next, López discussed the sociogram project in Colombia and suggested that proactive assessment of community strengths and needs are necessary for adequate and appropriate responses to emergencies. The author also highlights the importance of including in assessments the potential social and emotional impacts on the community. Following López, Romero's project addresses men's rights to participate in child rearing in Chile; this concerns an issue that is not unique to Chile but provides perspectives and strategies that could be used to inform service approaches with families in the United States that are facing similar challenges. Last, the recommendations for school program elements made in the final paper, by Montemayor and Vázquez, regarding the school system in Tamaulipas, Mexico provide a clear pathway for the application of research to real world situations in schools and communities, particularly with regard to the contrast between rural and urban contexts.

Each of these projects has arisen in response to specific community issues and seeks to improve the lives of children and families through better understanding of family, school and community resources and risks. An emphasis on the identification of strengths as well as needs is evident across projects, as well as a deep sense of community responsibility and the need for the involvement of both professionals and family/community members in identifying and addressing issues. Each project is also engaged in reforms of systems, institutions and societal attitudes that are difficult to change, and present challenges similar to those faced by systems of care. In response to these challenges, presenters have provided examples of creative efforts to develop tools and strategies that have been effective in engaging various sectors of communities as well as being applicable to immigrant transnational populations.

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