Chapter Seven

Sensitivity to Culture in Systems of Care

Symposium–The Inter-American Consortium for Applied Research on Children and Communities:

Understanding and Addressing the Mental Health Needs of Latin America's Poor and At-Risk Children Through Educational and Community Development Programs

Acknowledgements: This symposium was presented by the Inter-American Consortium for Applied Research on Children and Communities and funded by the Matilda Garcia Initiative: Latin American Research Scholars Exchange. Additional funding was provided by the Children's Board of Hillsborough County, and the Latin American and Caribbean Studies program at the University of South Florida.

Co-chairs
Linda Callejas
Teresa Nesman

Authors
Ana Lucía Montemayor Marín
Victoria G. Lidchi
Natalie Roxana Loncharich Vera
Irene Rizzini
Fernando Peñaranda Correa et al.

Symposium Introduction

Linda M. Callejas

This symposium discusses findings from research, evaluation and demonstration projects that address current issues affecting poor children and communities in various countries of Latin America. The papers examine some of the structural social, cultural, and economic conditions that provide the context for children's daily lives, as well as some of the community-level manifestations of these structural conditions. The researchers link their studies to larger 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. The author of the first paper discusses the impact of migration on family and adolescent student well-being in Tamaulipas, México. The second paper discusses the use of underlying cause analysis in the development of more effective child protection programs and policies in Brazil and Bolivia. The third and fourth papers focus on the widespread problem of "street children" in the large urban centers of South America. The third author discusses the results of a qualitative research project conducted with street children engaged in prostitution in Lima, Peru; the fourth paper focuses on research findings that highlight emerging strategies for providing support to low-income families whose children are at risk of leaving home and living on the streets of Rio, Brazil. The final paper presents evaluation findings of a program that aims to improve educational, health, and social services in low-income areas of Colombia through innovative community development programs. The research findings here presented provide unique perspectives, tools and philosophical approaches that can enrich the repertoire of systems-of-care research and practice.

Family and Migration: A Profile of Migrant Families in Tamaulipas, México

Ana Lucía Montemayor Marín

Introduction

This paper presents the preliminary findings of research on the impact of migration on family and adolescent student well-being in Tamaulipas, México. The study analyzes the impact on these families in terms of psychological, sociological, political, cultural, educational and economic indicators. The My Community Identity Project was developed to challenge adolescents from migrant families to construct their own life goals and work toward achieving them. The project develops awareness and communication capacities with an innovative methodology of collaboration with the adolescents sampled. The project aims to provide adolescents with tools to continue to learn throughout life with both freedom and responsibility.

Methods

The study was exploratory, and investigated correlations between the variables of family dynamics and socioeducational adaptation. The sample included 2,135 migrant families whose children were in high school. Qualitative information was collected through life histories and interviews, combined with demographic information from the State. We gathered information to understand the perception of the student and his or her family about family life, country or region of origin, family structure, lifestyle, integration and socioeducational achievement. The units of analysis included family, father, mother, and children; and work, social, educational, cultural, economic and community environments. We integrated life stories and measures of well-being to describe the psychological, sociological, political, educational, cultural, and economic aspects affecting students and their families. The analysis showed that migration both into the State of Tamaulipas and across the border to the U.S. has a significant influence on the culture, family and individual, as well as in the social and economic development of the State.

Results

Family profile. Over 77% of families were nuclear in composition, with some having new configurations as temporary single-parent households due to migration of the father for work. Single-parent households correlated with changes in the identity and development of youth cultures. Changes were associated with mothers becoming heads of households, with increased self-esteem and autonomy, but also with the increased burden of responsibility for both the family income (often through informal sector work) and the moral development of the family. These families also showed decreased affection and instability related to an absent or weak father figure.

About 60% of the families surveyed were temporarily single-parent and extended. That is, the children were cared for by the community or stayed with neighbors or other family members while their parents migrated for work. Many of these adolescents dropped out of school in hope of a better life and worked in order to prepare to cross the U. S. border themselves. They also became sexually active at earlier ages, with many young men leaving young mothers with children behind when they migrated. Due to in-migration and out-migration over the past 11 years, a social transformation has resulted at the community level. Over 66% of families that migrate into the community hoping for better conditions settle in poor areas and decrease in well-being—as evidenced by increased instances of anxiety and depression. However, due to the contributions of new populations, migration has also promoted cultural, scientific, technological and artistic advances.

Conclusions

The findings suggest three points: (a) migration patterns have interrupted the traditional family structure, (b) emigrant families create their own unique culture, and (c) there is an impact on the youth capacity for socioeducational integration.

Emotional and communication barriers deter the integration of the emigrant adolescent to the family and social environments. The organizational structure of the Tamaulipecan family is changing because of high rates of migration, resulting in new social configurations that affect parenting strategies. This social transformation has created a different lifestyle. Migrants are often at risk of social problems, although positive changes have occurred in women's self-esteem through involvement in work. A great number of migrants do not have satisfactory levels of social well-being, and seem to live with an imaginary hope of a better life that will modify their attitudes and conducts.

Figure 1
Types of Family: Nuclear, Divided, Extended, Alone

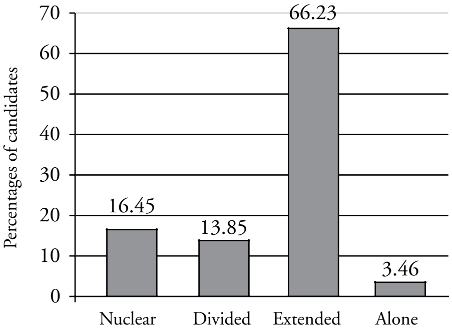


Figure 2
Migrant Families
Time of Being in a City

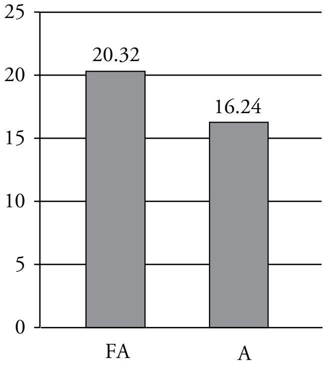


Figure 3
Socio Economical Level

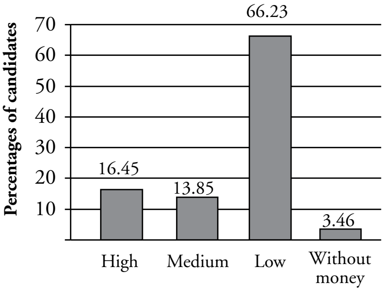
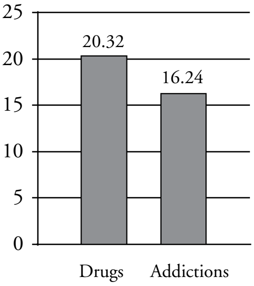


Figure 4
Family and Health



The Use of Systemic Principles to Maximize Resources and Promote the Creation of Child Protective Networks

Victoria G. Lidchi

Introduction

Reviews of international achievements in the field of child protection include the advances in the diagnosis and identification of child maltreatment, the development of interventions and services, and the propagation of research through publications (Lachman & Poblete, 2002). Despite the resources available in some countries, it is clear that great challenges exist in improving the condition of children in many others (Ebigbo 2002; Killian 2002; Nyandidya-Bundy & Bundy, 2002; UNICEF, 2001;).

This paper illustrates how *underlying cause analysis* can be used to identify obstacles to applying global frameworks faced in South America. It is suggested that systemic principles can help structure intervention programs in the area of Child Abuse and Neglect (CAN) that take into account local difficulties by: (1) using existing resources and delivery systems, (2) building on these resources for an integrated multisectorial approach focused on CAN, and (3) providing the context for investigating how existing structures and systems may be cooperatively mobilized using local professional networks.

International frameworks applied locally in Latin America

Important frameworks structuring world-wide child protection intervention work include: (a) the Convention on the Rights of the Child (CRS; United Nations, 1990; Forrester & Harwin, 2000; UNICEF, 1998), and (b) the declaration by the World Health Organization that child maltreatment is a public health issue (WHO, 1999). By signing the CRC, Latin American countries testified to their commitment to child welfare and the recognition of principles developed by international agencies as a basis for review of national legislation (Peralta & Reartes, 2000; Rizzini, 2002; USP, 2000). The 1990s saw legislative and institutional initiatives as well as the growth of epidemiological work on violence and abuse—a preparatory step to a public health approach (Bringiotti, 1999; CEDIB, UNICEF & Terre des Hommes, 1997; Farinatti, Fonseca, & Brugger, 1990).

Despite this commitment, improving the welfare of children takes place in difficult social and economic conditions. Writings on domestic violence implicate the social context of patriarchy and a historical legacy of military dictatorships in South America, with family structures reflecting the societal norms of authoritarianism (Barudy, 1992; Ellsberg, 2000; Ravazzola, 1997). Commentators also associate social factors such as poverty and social inequality with interpersonal factors in generating abusive patterns (Barudy, 1998, 1992; Ravazzola, 1997) in order to justify the need for social and political change in parallel with specific child protection measures (CEDIB, UNICEF and Terres des Hommes, 1997; Concha-Eastman, 2000; Hecht, 2000).

Methodology

Pre-conditions and underlying causes

The analysis of underlying causes—or *Tripod methodology* (Tripod International, 2002)—is a technique developed for accident and injury prevention investigations. The advantage of this type of analysis is its identification of processes and systems that have wide-reaching effects on safety, rather than with immediate causes[1]. The underlying cause analysis was used to understand how complex, interrelated factors influence the origins and development of CAN cases in Latin America.

Systemic framework

Interviews and lectures in Bolivia and Brazil uncovered how limited resources, competing priorities and lack of well defined child protection structures and processes can obstruct progress. A framework was needed to address these challenges; it would have to take into account the identified contextual complexity, and facilitate creative intervention strategies using existing resources.

Systemic thinking inside and outside Latin America has addressed how factors outside families maintain abusive and neglectful interpersonal interactions (Bentovim, 1992; Furlong, 1996; Furniss, 1991; Smith, 1993;). Unraveling the contribution of intra-familial factors and extra-familial or structural contributions –the South American literature places great emphasis on the analysis of the latter (Ravazzola, 1997; Barudy, 1998) has helped develop comprehensive assessments and multi-leveled interventions (Furniss, 1991; Glaser & Frosh, 1993; White, Essex, & O'Reilly, 1993). The systemic framework is consistent with the developmental-ecological approach to CAN (Belsky, 1993; Cicchetti & Lynch, 1993); each approach stresses the complex, mutual influence of risk and resilience factors operating at the social, cultural, family and individual levels (Barudy, 1998; Horwitz, Wisdom, Claughlin, & White 2001; Reder & Duncan, 2000). Systemic theory and practice has developed a number of techniques that foster collaborative work and, during the last decade, has moved toward a solution focused, resource-based approach (Durrant & White, 1992; George, Iveson, & Ratner, 1990).

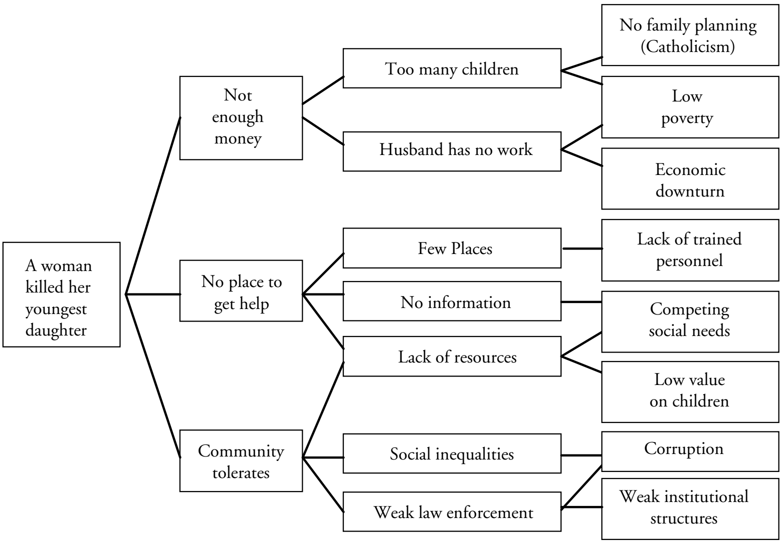
---

[1] *The Tripod methodology was developed in the 1980s, by scientists at Manchester and Leiden Universities under contract from commercial entities wishing to improve their management of Health and Safety. The analysis here was modeled on the tripod B analysis, which looks for hidden causal pathways underlying the "facts" of an accident.*

Results

By applying the underlying cause analysis to a case of infanticide in Bolivia, for instance, paths may be elaborated to identify pre-conditions and failed strategies indicating sites of intervention to prevent future CAN occurrences (see Figure 1) This analysis suggests that CAN may be effectively tackled by incorporating child protection efforts into broader-based programs that address social issues.

Figure 1
Underlying Cause Analysis



Informed by such analyses, training courses using systemic thinking were developed in Bolivia and Brazil to identify how barriers can be strengthened along some of the paths identified as contributing to CAN. These training courses were organized with international cooperation and ranged in format from a two year university postgraduate diploma in systemic analysis and intervention in Bolivia (in collaboration with the Institute of Family Therapy in London) to short courses such as a three-day event held in Rio de Janeiro sponsored by the International Society for the Prevention of Child Abuse and Neglect. These initiatives prioritized multi-disciplinary and multi-sectorial approaches to foster collaboration and the creation of child protection networks.

The training programs aimed specifically to help participants: (a) identify how existing resources may be used to promote child protection, (b) analyze how child protection policies or practices may be implemented more effectively and efficiently, and (c) systemically understand the current obstacles in order that they may be avoided when planning future interventions. Examples are given below of some key systemic principles and how they were reflected in the training:

1. A resource based, solution focused methodology that notices resources within the system/context in order to generate new patterns from within (George et al. 1990; Durrant & White, 1992). It is recognized that existing agencies need to understand the principles of CAN prevention if they are to understand how these principles are being/can be incorporated into existing delivery systems focused on health, sanitation and education. In Bolivia, members of the Programa Nacional de Atención a Ninas y Ninos Menores de Seis Anos (PAN, 1997) used government-funded access channels in rural areas to promote primary prevention initiatives. PAN members noticed the beginnings of a preventative approach in the discussion groups they were holding for parents on non-violent parenting techniques. These discussion groups developed and extended the prevention aspect to issues such as gender assumptions in the parenting of boys and girls, and the benefits of child education as opposed to work. In Brazil, teachers and school nurses exchanged ideas on how they had been approaching the human body and sexuality in the classroom, and how this could be developed into contextually appropriate educational programs with a preventative function for issues such as sexual abuse.

2. Respect and collaborative working to aid interventions (Barnes, 1998). Lack of cooperation between nongovernmental organizations (NGOs) themselves and official authorities is a recurring concern. In Brazil, one of the most important outcomes of the training was the networking that occurred between different government agencies and between agencies and NGOs.

Assumptions about the roles and responsibilities of these groups were leading to inappropriate referrals, the shifting of responsibility from one group to another, and accusations of unprofessionalism. Training helped facilitate discussions, and the exchange of information promoted mutual understanding between agencies and NGOs about the work settings and constraints of each group. This process also led to new thinking about how to develop a more collaborative vision by using each group's shared and complementary skills and approaches. For example, NGOs had creative ways of developing independent programs that were framed to complement the more structured service approach of government agencies that often do not reach needy populations (i.e., street children, child workers, and children in rural and poor communities such as the *favelas*).

In Bolivia, a re-occurring concern for the professionals in training was, among NGOs, how collaboration was undermined by the existence of multiple priorities leading to the belief by each agency that it was working on behalf of the "most needy group." Competition for resources and poor communication had obscured the links between the interests of the different groups and the opportunities for cooperation. A systemic analysis of patterns and mutual influence revealed how the needs of the various groups were related, allowing the participants from different agencies to move toward designing cooperative intervention initiatives. For example, links between rural poverty, institutionalized children and child workers were examined. In such cases, girls from impoverished areas are sent to the city to find work as nannies or maids, where they may be maltreated or taken advantage of by employers; as a result, they either run away or get into trouble with the legal system for problems such as alleged or actual theft. Other examples include child laborers and child prostitutes, who often provide important sources of income for families who move to the city in search of work but may not find it. Thus, children who beg on the city streets may be giving their money directly to their family—or their labor may be rented by the family to an informally organized group.

3. Beliefs and actions being linked in a circular way where small changes in either beliefs or actions can trigger larger changes (Jones, 1991; Barnes, 1998). The training in Bolivia led to a change in the models used by some agencies, reflecting modified beliefs. The Centro de Ayuda Psicológica (Centre for Psychological Help; CAP, 2001), an organization providing counseling to female victims of violence and abuse, shifted its orientation from a feminist human rights perspective to a systemic one in order to better address the link between violence against women and their children, as well as intergenerational abuse.

The *Proyecto de Erradicacion del Trabajo Infantil* (Program for the Eradication of Child Labour; AECI, PROFANA & IPEC, 2000) changed its focus from the child to the family and its context. Families were educated about the long-term value of training, as opposed to the immediate revenue earned by working. An appreciation of the families' social context and collaboration resulted in workers coming to terms with the reality of their children's income-generating function, and with parents allowing their children to attend educational programs. The educational program also included a practical component to satisfy parental concerns that the children were also learning useful income generating skills.

Conclusion

The experience of training programs in Bolivia and Brazil indicates that international conventions and guiding principles are a foundation for promoting child protection policies and practices. Addressing CAN locally can effectively be done by recognizing other social needs, and by integrating child protection concerns into existing activities. Analyzing structures and obstacles and applying systemic principles to overcome them can promote collaboration, professional networking and programs to advance CAN objectives.

References

AECI (Agencia Espanola de Cooperación Internacional) PROFANA (Programa niño/a, adolescente y familia and IPEC (Programa Internacional para la Eradicación del Trabajo Infantil. (2000). *Proyecto de erradicación del trabajo infantil: Unidad vecinal 79 AB, Santa Cruz de la Sierra Bolivia*. PROFANA: Santa Cruz.

Barnes, G. (1998). *Family therapy in changing times*. London: MacMillan.

Barudy, J. (1992). La violence comme organisatrice de la subjectivité individuelle, familliale et sociale. *Neuropsychiatrie de l'enfance 40*, 373-377.

Barudy, J. (1998). *El dolor invisible de la Infancia: una Lectura Ecosistémica del Maltrato Infantil*. Barcelona, Buenos Aires, México: Paidos Terapia Familiar.

Belsky, J. (1993). Aetiology of child maltreatment: A developmental-ecological analysis. *Psychological Bulletin 114*, 413-434.

Bentovim, A. (1992). *Trauma Organised Systems: Physical and sexual abuse in Families*. London: Karnac Books.

Bringiotti, M. G. (1999). *Maltrato infantil: Factores de riesgo para el maltrato físico en la población infantil*. (Mino & Davila, Editores). Madrid: Arroyo Fontarron.

CAP (Centro de Ayuda Psicológica). (2001). *Experiencia psicológica del CAP: Pampa de la Isla 1999-2001)*. Santa Cruz, Bolivia: Ministerio de Trabajo y Asuntos Sociales and Instituto de la Mujer.

CEDIB, UNICEF, Terre des Hommes. (1997). *La Huellas de la Violencia*. Bolivia: Terre des Hommes Alemana.

Cicchetti D, & Lynch, M. (1993). Towards an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry 56*, 96-118.

Concha-Eastman, A. (2000). Violence: A challenge for public health and for all. *Journal of Epidemiology and Community Health, 55*, 597-599.

Durrant M, & White, C. (1992). *Ideas for therapy with sexual abuse*. South Australia: Dulwich Centre Publications.

Ebigdo, P. O. (2002). The effect of poverty on child protection in Africa. *Child Abuse and Neglect, 26*, 592-596.

Ellsberg, M. C. (2000). *Candies in Hell: Research and action on domestic violence against women in Nicaragua*. Sweden: UMEA University Medical Dissertations.

Farinatti, F. A, Fonseca, N. M, Dondonis, M, & Brugger, E. (1990). Child abuse and neglect in a developing country. *Child Abuse and Neglect, 19*, 1313-1321.

Forrester, D., & Harwin, J. (2000). Monitoring children's rights globally: Can child abuse be measured internationally? *Child Abuse Review 9*, 4217- 439.

Furlong, M. (1996). Cross-purposes: Relationships patterns in public welfare. In C. Flaskas & A. Perlesz (Eds.), *The therapeutic relationship in systemic therapy* (pp. 176-194). London: Karnac Books:.

Furniss, T. (1991). *The multi-professional handbook of child sexual abuse: Integrated management, therapy and legal interventions*. London: Routledge.

George, I., Iveson, C., & Ratner, H. (1990). *Problem to solution: Brief therapy with individuals and families*. London: BT Press.

Glaser, D. & Frosh, S. (1993). *Child sexual abuse* (2nd edition). London: MacMillan Press.

Hecht, T. (2000). In search of Brazil's street children. In C., Panter-Brick & M. T. Smith (Eds)*, Abandoned children*. Cambridge: Cambridge University Press.

Horwitz, A., Spatz Wisdom, C. M., Claughlin, J., Raskin, & White, H. (2001). The impact of child abuse and neglect on adult mental health: A prospective study. *Journal of Health and Social Behaviour 42*, 184-201.

Killian, B. (2002). Is child protection possible in areas of war and violence. *Child Abuse and Neglect*, *26*, 600-617.

Lachman, P., & Poblete, X. (2002). Challenges facing child protection: Overview—lessons from the "South". *Child Abuse and Neglect, 26*, 587-592.

Nyandiya-Bundy, S., & Bundy, R. P. (2002). The Influence of HIV and Aids on child protection. *Child Abuse and Neglect, 26*, 596-600.

PAN y Ministerio de la Presidencia. (1997). *Programa Nacional de Atención a Niñas y Niños Menores de Seis Anos*.La Paz -Bolivia: PAN Nacional.

Peralta, M. I., & Reartes, J. A. (2000). *Niñez y Derechos: Formación de Promotores de Derecho de la Ninez y Adolescencia: Una propuesta Teórica-Metodológica. Espacio Editorial*: Buenos Aires.

Ravazzola, M. C. (1997). *Historia Infames: Los Maltratos en las Relaciones*. Paídos Terapia Familiar: Buenos Aires, Barcelona, México.

Reder, P. & Duncan, S. (2000). Abuse then and now. In P. Reder M. Mcclure, & A. Jolley (Eds.), *Family matters: Interfaces between child and adult mental health*. (pp. 38-54). Philadelphia: Routledge

Rizzini, I. (2002). *A Criança e a Lei no Brasil*. Rio de Janeiro: UNICEF-CESPI/USU.

Smith, G. (1993). *Systemic approaches to training in child protection*. London: Karnac Books.

Tripod International. (2002). Retrieved May, 2002: http://www.tripod.nl UNICEF. (1998). *Indicators for global monitoring of child rights*. Summary report and background papers, Division of Evaluation, Policy and Planning. New York: Author.

United Nations. (1990). *Convention on the Rights of the Child*. Geneva: Author.

USP-Editorial. (2000). *Código del Niño, Niña y Adolescente*. La Paz: Bolivia.

White. J, Essex, S., & O'Reilly, P. (1993). Family therapy, systemic thinking and child protection. In *Using Family Therapy in the Nineties*. In J. Carpenter & A. Treacher (Eds.), Oxford: Blackwell. World Health Organization. (1999). *Report of the consultation on child abuse prevention*. Geneva: Author.

Discourses of Street Children Engaged in Prostitution in Peru

Natalie Roxana Loncharich Vera

Acknowledgements: This research was partially funded by the Ford Foundation's Sexual and Reproductive Health Project, Universidad Peruana Cayetano Heredia.

Introduction

In Peru, as in other countries, the streets are not simple avenues—places for transit, meetings, work, and commerce—they are also "home" to many people, including children. We often see these street residents during the course of our day, and yet we often react indifferently to their presence in these public spaces. Children, who are vulnerable to exploitation from others, are also at risk of moral and physical danger. A number of girls and young women who live on the street engage in prostitution voluntarily—in some cases because adults force them. They may also turn to crime and drugs. This situation leads us to describe the characteristics of the *niñas de la calle* (girls of the street) who engage in prostitution, and to identify the conditions and mechanisms of prostitution, the reasons why they feel compelled to engage in this practice, and to identify the risks associated with prostitution and individual and public health.

Methodological Approach

The study relied on a phenomenological approach to guide the research in order to elicit and relate study participants' experiences from their subjective perspectives—relying on their own words and discourses—especially with regard to their involvement in prostitution. Surveys were carried out on the first and second blocks of the Avenida Grau, Cercado in Lima, Peru. The study population was comprised of girls who work or have worked as prostitutes and who live in the intervention zone of the program, *Amigos de la Calle* (Friends of the Streets) housed at the *Instituto Peruano de Paternidad Responsible* (INPPARES; National Institute for Responsible Parenthood). Six girls were interviewed and their recorded experiences form the basis of this study. Specific methods used include observation and in-depth interviews.

Results and Discussion

Niñas de la calle who work as prostitutes

The average age of study respondents was 16 years old. This is not the age at which they left their houses, however. The majority of respondents reported living on the street for more than three years, almost the same length of time that they reported working as prostitutes (see Table 1). All of the girls who were interviewed claimed that they had relatives in Lima. They also all reported having come from Lima, belonging to the group of *niñas de la calle* that migrated to the city's downtown[1]. Four of the girls reported being raised in families with a step-parent, and the remaining two respondents were raised in single-parent households with only the mother present (see Table 2).

Reasons and motivations for leaving home and working as prostitutes

Inability to meet basic needs. One of the main reasons the girls identified for leaving their homes was the lack of household funds to satisfy the family's basic needs, particularly nutrition. This inability to meet basic needs by poor families often forces children to seek work outside of the home. They begin work at a young age (prior to adolescence) and contribute to the family income. The common factor for leaving home is poverty.

---

[1] *Aproximately 65% of children of the streets come from other parts of the country and the 35% come from outlying areas of the city. INPPARES: Proyecto Amigos de la Calle.*

Table 1
General Data "Girls of the streets" who Work as Prostitutes

Name	*Age*	*Origin*	*Time At Street*	*Time In Prostitution*
Fiorella	17	San Juan Miraflores	5 years	5 years
Sandra	17	Villa María del Triunfo	4 years	4 years
Charo	17	San Martín de Porres	Almost 3 years	2 years
Daysi	15	San Juan de Lurigancho	3 years	3 years
Giohana	14	Lima	1 year and a half	1 year
Diana	16	Villa El Salvador	3 years	Almost 3 years

Table 2
Type and Familiar Contact and Boyfriend
of the "Girls of the Streets" Who Work as Prostitutes

Name	*Type of family*	*Contact with family*	*Boyfriend*
Fiorella	One parent	Sometimes she visits her brothers that are in Albergues	Has a boyfriend. He knows she is a prostitute, and does not agree.
Sandra	Rebuilt	None	Has a boyfriend He does not know she is a prostitute.
Charo	One parent	Sometimes she visits her mother. She does not live with her.	She has a boyfriend that she visits sometimes. He knows she is a prostitute and does not agree.
Daysi	Rebuilt	None	No boyfriend
Giohana	Rebuilt	None	No boyfriend
Diana	Rebuilt	None	No boyfriend

Family violence. As noted above, many of these girls grew up with step-parents because their own fathers were either unavailable or absent:

"My stepfather…my biological father didn't want to recognize me, so my stepfather did" (Giohana, 15).

Most of the girls interviewed reported being exposed to family violence in their homes, from an early age. Domestic violence was another main reason cited as a causal factor in leaving the home:

"…my stepfather..my stepfather..uhh..and my mother…they used to fight all the time…everyday… and when my siblings went to school but I didn't…my stepfather took it out on me" (Fiorella, 17).

Social science theorists suggest that the large-scale economic conditions of developing nations often results in adverse, local social relationships, affecting marriage, family, and sexuality. As Giddens (1999) notes, "…these aspects of globalization contribute to pressures and tensions that affect all the traditional ways of life in the majority of the regions on the world." The family problems reported by respondents were numerous. However the majority of these families were defined as dysfunctional families because it was not possible to establish a well-defined typology (Serrano Mercado, Serrano Bascopé, & Verónica, 1999).

Sexual Violence. Most of the respondents reported being initiated into sex by their father or stepfather, with sexual abuse beginning most often before the victims were 10 years old:

"...when I was 9...my father raped me…my stepfather" (Giohana, 15)

"...because my father raped me…" (Daysi, 15)

Alcohol abuse is often a common factor in families exhibiting problems of domestic violence and sexual abuse. Alcohol abuse on the part of a father or step-father, coupled with the stresses of life in poverty, can make family life a dangerous one for many girls who are being raised under such circumstances (Freyre, 1997). According to Claramunt (1998), "A connection between sexual abuse during childhood and prostitution has been found. The girls and women involved in prostitution experience a chain of ruptures of confidence and personal boundaries and therefore they can not protect themselves."

Further, victims of sexual abuse often receive a double message: they are vulnerable and yet, appreciated as objects (Quintanilla Zapata, 2000). Thus, Trapasso (1992) contends that sexual abuse victims receive the message that they are only appreciated if they can satisfy men and serve as an object of lust for them.

Self-perception in the present and future

Present. Many of our respondents indicated having negative feelings about themselves, including feelings of inferiority that they say makes them a pobrecita (poor thing) among their peers. Such feelings often lead them to talk about themselves in a pejorative manner in front of others. The girls in the study exhibited a number of negative self-perceptions: they demonstrated lack of self-confidence, low self-esteem, and a damaged self-image, and they reported feelings of shame and guilt.

Future: A different image. Overall, our respondents indicated that they project a positive vision of the future for themselves that does not involve prostitution or living on the street. Education and training are among the expectations they report as a projected means of escaping their current reality. Most of the girls said they believed that an education would allow them to earn an income that would not require them to engage in prostitution. However, many of the girls noted that despite the stigma of being prostitutes, they were able to secure an income that might some day help them to escape the very sense of marginalization that they feel because of this activity.

Individual and public health risk

Risk of physical violence on the street. Physical violence while on the job is a risk that many of these girls run on a daily basis. In addition, violence may also be experienced at the hands of the peers—many of the girls reported that the "smarter ones" take advantage of the "new ones" because they have not yet grasped the rules and codes of the street.

Risk of unplanned pregnancy and abortion. Not surprisingly, the girls engaged in these practices run a near-constant risk of unplanned pregnancy and its attendant consequences. In order to continue to ensure a viable income, some of them continue to work despite pregnancy. Others have illegal abortions and risk their lives by undergoing procedures in unsanitary and/or dangerous conditions.

Risk of contracting STD and HIV/AIDS. Through the interviews, it became evident that these girls had received basic information about STDs and HIV/AIDS, but they were not taking preventive and effective measures to avoid infection. Although respondents indicated that they knew that the use of condoms could drastically reduce this risk, they cited the "issue" about the use of condoms in their line of work. Many of their clients simply refuse to use condoms; other times respondents felt their use was unnecessary. It is possible that respondents are conversant in the social discourse about condom use as the best way to prevent STD and AIDS, despite their lack of use. We hypothesize that although the *niñas de la calle* do receive information regarding condoms, the information they receive is often limited and, due to their relatively young age, they may feel invulnerable to the realities of STD and HIV/AIDS transmission.

Drug consumption and mental health. Many of our respondents reported sniffing Terokal (industrial glue) before or during the performance of the job as common. Many also claimed that clients sometimes bring drugs, most often cocaine and marijuana, to their encounters. Consumption of these substances was reported as being requested or encouraged by clients, and the girls said they felt that they had to accept them as part of the encounter.

Conclusions

The *niñas de la calle* who engage in prostitution and who participated in this research do not conform to popular stereotypes of prostitutes. Prostitution is often seen as a complicated occupation with a number of rules and regulations that are related to the service and/or payment conditions, by which these rules serve to secure more monetary benefits for the prostitute, who is seen as being in control. However, the main reason or motivation given by our respondents for working as prostitutes is to satisfy basic needs and to survive a difficult life on the street. The drug addiction reported here, especially with regard to the terokal, was often reported as a means by which to escape reality or as a condition or need for completing their services. We also found that the desire of many of these young girls for social and emotional support and to fit in with the street culture make them susceptible to peer pressure; this reinforces their choice to remain prostitutes, following initiation. While prostitution has a practical meaning as a means for these girls to earn money and satisfy their needs on the streets, it also provides them with a community in which to belong.

References

Claramunt, C. (1998). *Explotación Sexual en Costa Rica: Análisis de la ruta crítica de niños, niñas y adolescentes hacia la prostitución*. San José, Costa.Rica: UNICEF.

Freyre, E. (1997). *La Salud del Adolescente: Aspectos médicos y psicosociales*. 2 Edición. UNSA Arequipa.

Quintanilla Zapata, T. (2000). *Prostitución, Derechos humanos y Libertad Sexual*. Documento de trabajo del Conversatorio Nacional sobre Prostitución. Lima.

Serrano Mercado, J. A., Serrano Bascopé, & M. Verónica (1999). *Maltrato y abuso sexual infantil. Problemas clínicos, preventivos y terapéuticos*. Bolivia: En Revista del Instituto Médico Sucre. Vol. LXIV No. 115.

"Vulnerable" Children and Youth in Brazil: Reflections on At-risk Children in Low Income Communities in Rio de Janeiro

Irene Rizzini

Irene Rizzini is currently a professor and researcher at the Pontifical Catholic University of Rio de Janeiro (PUC, Department of Social Work). Professor Rizzini is the Director of the International Center for Research and Policy on Childhood (CIESPI) at PUC (Pontifical Catholic University of Rio de Janeiro) and the President of Childwatch International Research Network (Oslo, Norway).

Introduction

For much of the 1980s and 1990s, the national and international media and local and international children's and human rights organizations focused considerable attention on the plight of "street children" in Brazil, particularly on violence against these children by death squads and police. Indeed, the symbol of child and youth poverty in Brazil, as presented in the national and international press and in numerous research reports, might be said to be the street child. In this paper, I argue that this focus on street children—however well-intentioned—deflects attention from the broader population of low income children and youth in poverty.

Methodology: Two Studies

In the last few years, most advocates working on behalf of street children have acknowledged the need to expand what they do to reach the much greater number of children and youth who are not yet living or working on the street but require assistance to prevent them from doing so, or simply to support their healthy development.

This paper is based on two studies carried out by the author and researchers from the International Center for Research and Policy on Childhood (CIESPI) team: the first study, "Children and adolescents situated on the street in Rio de Janeiro – weaving their stories…" took place between October 2001 and

January 2002 and involved a total of 120 people, over half of whom were the youngsters interviewed on the street. The study highlights the life trajectories of these children, focusing on the following dimensions: (a) the multiplicity of links and trajectories, (b) day to day life, (c) mobility, and (d) identity and subjectivity.

The second study, *Bases de Apoio* (bases of support), is a research-action project that maps family and community-based developmental supports for residents of *favelas* (i.e., a hillside squatter settlement on the outskirts of a Brazilian city) in Rio de Janeiro. The project focuses on providing family and community resources for the holistic development of children and youth, with the aim of envisioning a system of developmental supports for all children and youth.

Study One: Vulnerable Children in Low-income Communities in Brazil

"Africa is Here. And so is Europe" was the headline of one of a series of reports that appeared in 2001 in *O Globo*, Brazil's leading newspaper. The articles were based on a recent report by the United Nations Development Program (UNDP), (the first of its kind to analyze the Human Development Index for the municipality of Rio de Janeiro and its many districts or *bairros*. "Africa is here. And so is Europe," refers to the suggestion that, whereas Rio's more affluent post-card *bairro* of Lagoa—perched near the sea and beneath the giant statute of Christ that stands in one of Rio's tallest hills—could claim a standard of living comparable to that of Italy, Rio's poorest *bairro*, Icaraí, has a standard of living comparable to Algeria To say that Rio, and Brazil more generally, is a land of contrasts is nothing new. What is new about the report, however, is that it put figures on what, for *Cariocas* (the residents of Rio), is all too evident: this modern international metropolis co-exists alongside degrees of poverty and destitution that have been unknown in Europe and North America for perhaps some 100 years.

The United Nations report chose Rio precisely because the co-existence of these two worlds seems so visible; and yet these are worlds that at times scarcely appear to meet. For many of the affluent elite who inhabit the beachside, highrise flats along Rio's stunning coastline, the reality of those who live less than a stone's throw away is the stuff of news bulletins. Yet the "neighbors" of these elite live in hillside squatter settlements or, *favelas*. *Favelas* have developed over the last 80 years or so, and today house 17% of Rio's population of over five-million. To the inhabitants of the *favelas*, the life of the elite is something only to be imagined and dreamed about through ubiquitous novelas (soap operas).

If the latest statistics are to be relied upon, the gap between these worlds, is exacerbated by an economic downturn, mass unemployment and a lack of opportunities. Yet if you live in a *favela* in the Zona Sul, closer to the affluent *bairros* and the sea, you are probably a lot better off than if you were to live in a settlement on the periphery. Built of bricks with electricity and sanitation, families here report a higher standard of living, with higher household incomes, educational standards and health indices, than do families who live on the periphery.

"Africa is here. And so is Europe" can also mean a lot more in the case of Brazil as a whole. It has been scarcely over 100 years since slavery was abolished in Brazil. The social debt accumulated during the era of slavery is yet to be settled in a country whose black and mulatto population of slave descendants are well represented among the poorest sectors of the population, including the children and adolescents found living on the street. This population contrasts with Brazilians of European descent, whose quality of life has developed along lines more akin to that of Europeans.

In the highly segregated communities of Rio de Janeiro, the so called "street children," appear to defy this social partitioning of space. By making their home on beaches, plazas, and in the doorways of shops and towering residences of the middle class, they are a reminder of the poverty and inequality of Brazil at the very heart of its modernity. In this defiance of social segregation, and perhaps as a consequence of it, the phenomenon of street children arises: a phenomenon, both in the sense of an actual occurrence and in the sense that street children become a social phenomenon. This situation draws attention from, and mobilizes different sectors of society—both nationally and internationally—in ways that range from progressive and constructive, to prejudicial and outright murderous.

In urban centers, these children and adolescents who sleep in parks and doorways, and beg or sell sweets at the traffic lights, are much more visible than the thousands of youngsters who live in at times worse conditions in urban *favelas* or rural poverty. While, these two worlds appear to co-exist in Rio, they represent parallel worlds that rarely meet. Being so visible by this defiance of social segregation and by appearing to fall outside common conceptions of the rightful space and shape of childhood, street children provide a bridge between both worlds.

Study Two: Vulnerable Children: Risk or Opportunity? Assumptions, Goals and Challenges as Societies

The adoption of the framework of rights globally made our countries more aware of the importance of respecting children's needs and perspectives. However, the fact is that our countries—poor or rich—have not been able to provide equal opportunities for all children. To the contrary, with the trend of privatizing even basic services such as health care and education in most countries, a growing number of families cannot afford decent services for their children. It also seems to be true in many countries that a growing number of children end up on the streets and in institutions due to a lack of alternatives for their own survival. This is the case despite the fact that the trend in legislation has been to keep children with their family and community settings whenever possible.

It should also be taken into consideration that in all our societies there are children who cannot be raised by their own families. We all believe that our systems should be capable of providing adequate substitute care for them, including institutional care when needed. However, that has not been the case in most countries.

Three interrelated assumptions guiding this project are:

- Children have special needs that need to be met in order to fully develop (i.e. to develop the capacities and potentials with which they were born);
- Children are young citizens; as such, they have the right to live in humane conditions that will allow them to fully develop;
- Parents, governments and societies in general have the co-responsibility to provide the necessary conditions for these children to fully develop their capacities and potentials.

As societies, one of our main goals is to understand how to provide children with appropriate care so they can grow up in nurturing environments that will allow them to fully develop their capacities and potentials. In the realm of caring for children, one of our current challenges is to understand the main complexities of providing such care—locally, nationally, and internationally. An important question for us to ask as we face these challenges is: "What is it that we, as individuals and societies, want for our children, and what can make a real difference in their lives?" These issues should not be disconnected from the political will and should be included as priorities in our countries' political agendas in order to transform them into real practices.

Having such goals and challenges in mind, let us now focus on the many children who are marginalized. One way of addressing the issue of children growing up in the margins of society is, by looking at their life course or trajectories, to focus on those who cycle downwards into child welfare and correctional systems.

The CIESPI team has been conducting a series of studies that focus on the life trajectories of children who are born in the low-income communities of Rio de Janeiro—from their lives in their homes, communities, and schools, to their passage into the streets and through several types of residential facilities. These institutions are supposed to protect them against the surrounding violence and several forms of abuse that affect them, but in practice have not been able to. One of the problems we face these days is the easy access these children have to guns and drugs; this is an international phenomenon and cannot be understood and dealt with only locally. The involvement of children in the drug trade in many of our countries is a reality. The drug trade attracts many children, and particularly youth, who for lack of alternatives see in it a source of power and easy income, though not for long.

We focus now on some emerging alternative strategies that constitute an attempt to tackle the roots of these problems by prioritizing preventive measures and, beyond that, promoting the development of children and youth who live in adverse circumstances.

Results and Lessons Learned

Emerging Alternatives for Family and Community Supports

Lessons learned about emerging strategies for community and family supports for children, based on research done in the Brazilian context in the past three years, are summarized below. The results are based on a project carried out in Rio de Janeiro in three very diverse, low-income communities with the following questions in mind:

- How are children and adolescents growing up within their families and communities?
- What kind of support do parents and other caregivers get for their children and for promoting their children's development? We call these developmental supports (or *bases de apoio*—bases of support);
- What formal supports for children and youth exist in the community – whether day care centers, youth programs, recreational activities and others? Which children and youth use these programs? What do they and their families think about these programs?
- What informal supports for children and youth exist in the community, and what do they represent in the lives of families and young people?
- How can we strengthen existing family and community supports or create other forms of support?
- How can we engage families and communities in this process?

The project *Bases de Apoio* (Bases of Support) has been mapping family and community based developmental supports in low-income communities in Rio de Janeiro to illustrate both the existence of supports and their potential for meeting the developmental needs of children and youth. This research resulted in the following four key conclusions:

- A number of formal services do exist in each community with staff who are driven and committed, yet these services receive very little technical or financial support from outside the community;
- The formal support services that exist in these communities reach a limited number of participants, have low awareness rates among youth and do not meet the extensive needs of youth and children;
- Informal supports reach a much greater number of children and youth, but there is little structured public assistance for these supports;
- Existing support services do not collaborate together, nor engage family members or their other informal supports in developing their services.

We should keep these findings in mind as we analyze a few issues that might give us some important clues as to what questions make sense to ask when thinking of informing policies and practices that aim at preventing children from growing up and away from their family and community environment. One of the key questions is: "What broad concerns should guide our attempts to improve the life conditions and life chances of children in low-income communities?" Several questions and a variety of answers may be similar for many countries but the emphases and the opportunities will be different in different places.

Conclusion

I conclude by returning my focus to one of the challenges mentioned in the early pages of this paper: to understand the main complexities in the lives of our children to identify factors that can make a difference to them and to identify ways to help us move toward impacting policies and practices so they meet children's needs.

In this paper I have discussed a few emerging trends that can be useful for this debate. Based on empirical data from research done in low-income communities in Rio de Janeiro, as well as the work of many others in several countries, I have pointed out the importance of strengthening what we called "bases of support" for children in their own life contexts, involving the family and the community in general. This can be done by supporting those who already provide support for children and youth and by creating new forms of support for them.

In the political sphere there are other important challenges. For instance, how can we establish national and international agendas that prioritize policies and practices that favor local participation? This is not an easy task. Different political groups will have an appetite for different agendas. Policy prescriptions must take into account the willingness of different political groups to work on an issue at any point in time. In Brazil, for example, the rule of the generals through centuries of dictatorships left the country with little experience of policy and social change advocacy, leaving a void that continues to be a major challenge.

Finally, it must be said that there will never be a single answer to reducing the number of children who suffer the dislocations of, for example, Rai—the Brazilian 15 year old boy whose life course we alluded to in this paper—to illustrate the ways in which children and youth end up trapped in the welfare system for lack of opportunities and alternatives. But we may be more effective if—having honestly looked at all the factors that go into this dehumanizing experience—we choose where we are going to put our individual and collective efforts, and then carefully choose those areas in which we think we can make the most difference.

PROMESA, Colombia: The Use of Qualitative Research and Evaluation Methods in a Community Development Program Focused on Children's Well-Being

Fernando Penaranda Correa, Marta Arango, Alejandro Acosta, Rober Myers, & Arelys Moreno

Acknowledgements: The Bernard van Leer Foundation financed the implementation of this project.

Introduction

The International Center of Education and Human Development (CINDE; *Centro Internacional de Educación y Desarrollo Humano*), is a private foundation in Colombia whose mission is to create environments supporting healthy childhood development as a basic strategy for overall human and social development. The foundation promotes activities to this end within the following areas: research, development of humanitarian services, and generation of innovative models to promote healthy childhood development (CINDE, 2003).

The Program for the Improvement of Education, Health and Environmental Services (PROMESA; *Programa para el Mejoramiento de la Educación, la Salud y el Ambiente*) was conceived as a community development program focused on childhood issues and carried out in the Pacific coast, in one of Colombia's most depressed zones. It was designed as a research and development program, whose lessons would influence the design and execution of programs and projects in other contexts. The project was initiated in 1978 with 400 families, and in 1998 was turned over to a local non-governmental organization (NGO) with 7000 families (Nimnicht & Arango, 2001).

An *action research and community development perspective*, characterized by its recognition of historic, political, socio-cultural, economic and ideological context, guides the program's research and evaluation framework. The CINDE vision regards research and evaluation as a means for the creation of positive change among social conditions and actors through the establishment of projects that adequately respond to community needs. This perspective relies on the use of participatory evaluation, recognizing a variety of needs across different participants and time frames. Such participatory processes of evaluation enable various community voices to emerge and cohere through a process of negotiation rather than competition or conflict. Community development projects are thus understood as social phenomena within which research and evaluation are utilized as fundamental strategies for the application of *teaching-learning processes* that allow community participants to gain a greater understanding of the social context affecting their lived experiences. Therefore, such understanding facilitates the adaptation of project objectives and actions in response to changing problems and needs in a world that is understood as constantly changing (Acosta & Peñaranda, 2002; Arango, 1983).

Because of its conceptual and institutional orientation and because of its participation in the Initiatives on Effectiveness program, CINDE emerged as the ideal vehicle through which to consolidate the research and evaluation objectives of the PROMESA project. PROMESA is a Foundation van Leer initiative aimed at uncovering the factors driving effective project implementation and initiating an international dialogue on program efficacy to increase knowledge on how to create or strengthen projects, programs and policies focused on early childhood development. This objective requires creation of a framework to outline the concept of efficacy from a variety of perspectives, actors, and contexts (Ilfeld, Evans & Salole, 1999; Foundation Bernard van Leer, 2000).

Methods

The study was carried out between 1999 and 2002, in conjunction with a variety of international NGOs and 10 projects identified as being effective and in operation for more than 10 years. Each of the projects provided a different focus and context that were studied by a multicultural team comprised of project members and international advisors (Ilfeld, Evans & Salole, 1999; Foundation Bernard van Leer, 2000).

The research was conducted using qualitative methods and analyses, with an emphasis on comprehension. It sought to move beyond the interview questions and answers themselves in an effort to validate subjects' intuition, and to transcend language and the conventional means for conducting research in a way that could uncover the programs' complexity. Although some general courses of action were defined, these were left open so that each research team could develop its own processes and resources (Salole & Evans, 1999).

The PROMESA evaluation relied on a mixed method research design, which included a document review of secondary sources and interviews conducted during workshops and meetings with children, parents, developers, community leaders, officials of collaborating institutions, present and retired advisors, and the founders and members of local financial agencies. Two field visits were also conducted: the first one to gather data, and the second to discuss findings with the study population.

The evaluation's analytic framework used the following categories: origin and genesis of the program; influences; philosophy, principles and values; organizational structure and culture; networks and ties; results and future. This analytic framework was revised to include the following final categories: project conception; project implementation and results in an effort to articulate a central project category; legitimacy and coherence.

Results and Discussion

One of the main factors identified as characterizing program efficacy includes the program's theory and philosophy, which rely on a theory of early childhood development that emphasizes the importance of understanding individual needs from a variety of perspectives, and that meeting such needs is a synergistic process.

Understood from an ecological perspective, early childhood development is seen as an assembly of environments that interact with each other and with which a child interacts throughout the development process. In this model, the significant adult provides the fundamental environment for early childhood development through the family environment, while simultaneously participating in the construction of other environments, especially student and community environments.

Such research places the human subject at the project's center, based on principles of equity and justice, in recognition that the development of these principles will strengthen the development of the individual. Individual participation played a central role in the program by allowing participants to shape their own development from a strength-based model focused on individual capacity and potential. As a result, education emerged as another one of the central analytical factors. Here, education is understood as providing fundamental training, which facilitated greater depth of individual participation. The research process was thus conceived as a form of community development designed to respond to the interests and needs of the community with respect to and efforts made to strengthen cultural identity.

Project implementation was structured in a way to effectively respond to the needs, interests, and characteristics of the community based on five processes that became goals in and of themselves. The first of these related to establishment of a *flexible method of learning* in the early development process. The second was a meaningful process of *community organization and participation* that generated the instruments necessary for individuals to act upon their development environments. The third was a *system of participatory management* through which the community and institutions collaborated to plan, execute and evaluate acts that were likely to promote community and individual development. The fourth was the strengthening of *inter-institutional coordination* needed to promote a basic understanding of development. The fifth was *access to resources* based on recognition of local capacities and potential thereby transcending dependency models of development.

These five processes were carried out through reliance on methodological and implementation principles stated explicitly at the program's outset, and by relying on a collective vision which further shaped these principles. Consultants involved in project implementation also took a more active role in the project by working to assist community members in becoming more involved in program activities for their own benefit. Leaders emerged directly from the community, recognized by their fellow residents for their skills and ability to articulate collective needs and interests. The project also sought to facilitate the creation of more horizontal and egalitarian relations among residents to generate the positive and safe psychological environments needed to promote learning, coordination, and cooperative work.

Research results revealed the importance of changes made in residents' lives, knowledge, and the development of individual capacity and potential; these changes allowed them to establish better environments for their children's development through strengthened parenting models, and to build capacity for effectively addressing living conditions and community development. Through these efforts the project was also able to transform the developmental environment within the family, allowing for greater harmony in effective family relationships. The consolidation of social networks and social capital within a framework of community organizations and participation served to strengthen the construction of a more effective and inclusive public space within which collective needs and interests might be better negotiated. Through this process, we recorded positive changes in individual and community self-perceptions and a heightened sense of cultural identity.

Because we were able to work with a variety of community groups—thereby identifying different needs and interests related to family and community environments—we were able to create a "critical mass" of concerned families and community leaders, which generated changes in a variety of childhood developmental environments. Through synergistic interaction between environments, these changes further resulted in concomitant changes to collective meanings regarding the role of women, community leaders, and developmental stages in early infancy, thereby ensuring future sustainability of the project and its community development results.

The participatory framework of the project relied upon a shared vision of its goals and principles. This framework facilitated the development of a sense of project legitimacy among its participants. This legitimacy was derived, in part, from: (a) a perceived coherence between the research proposal and its implementation, (b) the level of collaboration that allowed for participant involvement in the overall research process, and (c) respect for participation as a valuable tool for achieving project goals and objectives.

References

Acosta, A. & Peñaranda, F. (2002). *Evaluación de proyectos sociales*. Sabaneta: CINDE

Arango, M. (1983). *Algunos conceptos de investigación que utiliza el Cinde en sus proyectos*. Sabaneta: Cinde. (Manuscrito no publicado).

CINDE. (2003). *Portafolio Institucional*. Sabaneta: CINDE.

Fundación Bernard van Leer. (2000, octubre). La Iniciativa sobre Efectividad. *Espacio para la Infancia, 15*, 3-5.

Ilfeld, E., Evans, J., & Salole, G. (1999, octubre). Mapping the contours of effective programming: the Effective Initiative 1999-1992. *Early Childhood Matters, 93*, 3-5.

Nimnicht, G. y Arango, M. (2001). *Promesa: un programa para el sano desarrollo físico, emocional e intelectual de los niños/as pequeños/as*. Sabaneta: Cinde.

Salole, G, & E., Evans, (1999, octubre). When ECD works: Mapping the contours of effective programming. *Early Childhood Matters, 93*, 7-17.

CONTRIBUTING AUTHORS

Alejandro Acosta, Ph.D.
Centro Internacional de Educación y Desarrollo Humano – CINDE, Cra 33 No. 91 – 50, Bogotá, Colombia, 571-2564116, fax: 571-2187598, e-mail: aaacinde@supercabletv.net.co

Marta Arango, Ph.D.
Centro Internacional de Educación y Desarrollo Humano – CINDE, Calle 77 Sur 43A -27, Sabaneta, Antioquia, Colombia. 574-2881274, fax: 574-2883991, e-mail: marango@cinde.org.co

Linda M. Callejas, M.A.
Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd.,Tampa FL 33612-3807, 813-974-4651, callejas@fmhi.usf.edu

Victoria G Lidchi, Ph.D.
Coordinator and Project co-leader (ISPCAN/CEIIAS), Rua Prudente de Morais 1668, Ipanema 22420-042, Rio de Janeiro Brazil, phone & fax: 0055 212 512-9773, e-mail: victorialidchi@aol.com

Natalie Roxana Loncharich Vera, M.P.H.
Principal Investigator, Universidad Peruana Cayetano Heredia, El Carmen Avenue # 625 San Roque Surco Lima 33 Perú, 511-274-1376/511-9904-7805, fax: 511-4822954, e-mail: nloncharic@upch.edu.pe or nloncharich@hotmail.com

Ana Lucia Montemayor Marin, M.A.
Cd. Victoria Tamaulipas, México, e-mail: analucy52@Ayaho.com.mx

Arelys Moreno, M.A.
Bernard van Leer Foundation, Eisenhowerlaan 156, 2517 KP The Hague, The Netherlandas, 070-3312221, fax: 070-3502373, e-mail: registry@bvleerf.nl

Robert Myers, Ph.D.
The Consultative Group on Early Childhood Care and Development, Insurgentes sur 4411, Ed. 7 Apto 302, Tlalcoligia D.F., 14430, México, 52-555-5734277, e-mail: rmyers@laneta.apc.org

Teresa Nesman, Ph.D.
Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa FL 33612-3807, 813-974-7414, nesman@fmhi.usf.edu

Fernando Peñaranda Correa, M.D., M.A.
Centro Internacional de Educación y Desarrollo Humano-CINDE, Calle 77 Sur 43A - 27, Sabaneta, Antioquia, Colombia, 574-2881274, e-mail: fpenaranda@cinde.org.co, and Facultad Nacional de Salud Pública de la Universidad de Antioquia. Calle 62 No. 52-59. Medellín. Colombia. 574-5106828, e-mail: fpenaranda@guajiros.udea.edu.co

Irene Rizzini, Ph.D.
Director, International Center for Research and Policy on Childhood, Catholic University of Rio de Janeiro, Caixa Postal 38002, CEP 22 451 970, Rio de Janeiro Brasil, 55-21-9432-3327 ext. 39, fax: 55-21-3114-1292, e-mail: rizzini@hexanet.com.br

Mental Health Services Research with Black Populations: Recruitment, Retention and Data Interpretation

Alfiee M. Breland-Noble
Monica J. Mitchell et al.
Guerda Nicolas
Erika D. Taylor
Terri L. Miller

Acknowledgement: This research was supported by NIMH grant T32 65742.

Introduction to the Symposium

Alfiee M. Breland-Noble

Research in the area of health disparities has increased in recent years with mental health being just one of the many areas in which disparities have been documented. In 2001, Surgeon General Dr. David Satcher commissioned an empirically-based report to illuminate the areas in which mental health racial disparities exist (U.S. Department of Health and Human Services, 2001). In accordance with the suggestions of the report, which included addressing treatment barriers and cultural competence in service provision, the purpose of this symposium was to articulate current evidence that identifies and addresses sociocultural factors related to mental health disparities for youth. The particular group of interest in this summary is Black/African-American children and adolescents. Specifically, we describe research related to the theoretical underpinnings of conducting mental health services research with this population and provide empirical data to support current research in recruiting and retaining participants and interpreting data from this population.

Dr. Breland-Noble provides an overview of the current Black American population, including definitions, empirical data and the overall conceptual and analytic framework that guided the symposium presentations. Dr. Mitchell and colleagues provide a summary of findings on African Americans in research studies, while Dr. Nicolas presents an overview of findings regarding the mental health concerns of Haitian Americans, the largest subpopulation of Blacks in the United States. Dr. Taylor reviews the empirical literature using the Afrocultural ethos as a framework for understanding African American child behavior, and Dr. Miller provides an overview of the current empirical literature regarding African American need for services, access to care, help seeking and referral, engagement and utilization, assessment and diagnosis, and quality and outcomes.

References

U. S. Department of Health and Human Services (2001). Mental Health: *Culture, race and ethnicity—A supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

Recruiting and Retaining African-American Children and Families in Clinical Research Studies

Monica J. Mitchell, Lori E. Crosby, Janelle Hines, & Julia H. Bloom

Introduction

Although African-Americans are disproportionately affected by a number of physical and mental health conditions, including diabetes, hypertension, stroke, sickle cell disease, and depression, they are under-represented in assessment and intervention research studies aimed at better understanding and treating these conditions (Warren-Findlow, 2003). Moreover, reducing and eliminating health disparities is contingent upon the successful recruitment and retention of African-Americans and other ethnically diverse participants into research studies and clinical trials (Wisdom, 2002). While there have been published commentaries on oversights and lessons learned with respect to recruiting African-American adult samples (Gorelick, Harris, Burnett, & Bonecutter, 1998), the literature offers few replicable culturally-based strategies for recruiting representative samples of children, adolescents, and their families, as mandated by the National Institutes of Health, the Centers for Disease Control and other federal funding agencies.

Methods

This paper discusses the importance and implications of ensuring ethnic representation in recruitment and research efforts, and presents strategies for overcoming recruitment and retention barriers, even in hard to recruit and high-risk for dropout samples. Additionally, this paper presents a methodology for targeting and recruitment strategies without stereotyping. It also presents strategies for obtaining informed consent while building trust, and encouraging participation without coercion. Strategies that have been successful in recruiting representative samples in the following three types of studies are: (a) phone survey, (b) focus group, and (c) clinical assessment studies. Critical aspects of planning and marketing a study, and recruiting and retaining African-American subjects are summarized below. Tips for successful, culturally-based strategies mentioned in other published studies can be found in Gilliss, et al., (2001), and Ashing-Giwa, & Ganz, (2000).

Phone Survey: Phone Survey to Assess and Improve African-American Adolescents' Satisfaction with Clinic Services

- Planning: Prior to implementing the study, a survey was conducted to determine where teens would most want to spend a $20 gift certificate. The top three choices of (1) movies, (2) mall, and (3) Target stores served as the incentives in flyers and letters marketing the study. The plan also included development of a timeline that would facilitate obtaining consent from parents and adolescents, completing the phone survey, and mailing the gift certificate within a 48-hour window.
- Marketing: The marketing plan included (a) having a "friendly face" in clinics to introduce the study and provide detailed informed consent information, (b) the mailing of a teen-friendly and culturally-inclusive letter to potential participants, creating "word of mouth" about the study, and (c) sending out fun reminder notes and personal thank you cards.
- Recruitment: Recruitment strategies included getting primary and alternate phone numbers and addresses at the first point of contact, creating parent enthusiasm, making the survey fast and developmentally-sensitive, and noting that gift certificates would be mailed on the day of completion.
- Retention: Completing the study within a tight time frame and finishing incomplete calls within 24 hours.
- All aspects of the recruitment and retention plan were IRB-approved.

Focus Group Study: Multi-Site Focus Group Study to Assess Treatment Issues Related to Sickle Cell Disease

- Planning: Planning included taking a survey of good dates and times for the event, developing a 21-day timeline from start to finish, addressing barriers such as transportation and child care, and obtaining broad endorsement for the study from trusted medical care staff.
- Marketing: Face-to-face, phone, and written communication was used to introduce the study. Correspondence and other details of the study were written in a "we need you" manner that was respectful of participants' backgrounds. The event also advertised a full lunch/dinner for participants and other family members and ensured that there was "something for everybody" to do.
- Recruiting: The initial letter was sent out explaining all aspects of their participation, followed by a personal phone call, a confirmation card and directions, a reminder card, and a reminder phone call. The "red carpet" was rolled out at every opportunity, even before the actual event. Transportation vouchers were provided to all parents and professional childcare was provided to children. Informed consent was obtained such that there were no "surprises," and a final thank you note was mailed to each participant.
- All aspects of the recruitment and retention plan were IRB-approved.

Assessment Study: Three-Phase Study on Growth and Nutrition

- Planning: Planning included developing a timeline for getting participants through the three phases of the study within 45 days. The plan stressed convenience for families and coordination and communication among research staff. The first phase of the study involved a semi-structured family interview, which provided a basis for retention in Phase 2 and 3.

- Marketing: An acronym was used to promote the study (S.T.R.O.N.G. Program). Flyers were culturally sensitive and provided critical details of the study and its importance. Convenience was stressed as home visitation was used in Phase 1 and 2 of the study. Word of mouth and "refer a friend" behaviors were encouraged.
- Recruitment: Subjects were recruited via face-to-face contact or physician/participant referrals. Details of the study were provided in full-length letter and cookbook formats for each Phase of the study. "Refer a family" cards were provided to participants upon completion. Birthday and holiday cards were used to maintain rapport and to track moves.
- Retention: All study materials were labeled with "who," "what," and "why" information, as well as a contact person and phone number for questions. Business cards and refrigerator magnets were also given to participants. Phone follow-up was provided at critical points of the study. Certificates of completion were promised and delivered upon completion of the study. Families were also invited to participate in an optional Phase 4 upon completion of the first three phases.
- All aspects of the recruitment and retention plan were IRB-approved.

Discussion

The three studies yielded recruitment and retention rates of 80-95% of eligible subjects, including high rates in hard to reach and high-risk for dropout populations. Important questions to consider in successful recruitment and retention were also identified, and include: (a) Why would participants say "yes" and why would they say "no?" (b) How can knowing these facilitators and barriers to participation be used to refine planning and marketing strategies? (c) Why would participants continue in the study and why might they drop out? (d) How much follow-up is enough to engage participants and how much is too much? (e) What factor should be considered in hiring and training a recruiter? and (f) What are the pros and cons of working with a third party when recruiting subjects?

References

Ashing-Giwa, G. K., Ganz, P. (2000). Effect of timed incentives on subject participation in a study of long-term breast cancer survivors: are there ethnic differences. *Journal of National Medical Association, 92*(11), 528-32.

Gilliss, C., Lee, K., Gutierrez, Y., Taylor, D., Beyene, Y., Neuhaus, J., Murrell, N.. (2001). *Journal of Women's Health and Gender-Based Medicine* Issue 1.

Gorelick, P. B., Harris, Y., Burnett, B. & Bonecutter, F. J. (1998). *The recruitment triangle: Reasons why African-Americans enroll, refuse to enroll, or voluntarily withdraw from a clinical trial.* An interim report from the African-American Antiplatelet Stroke Prevention Study (AAASPS).

Warren-Findlow, J. Prohaska, T. R., & Freedman, D. (2003). Challenges and opportunities in recruiting and retaining underrepresented populations into health promotion research. *Gerontologist, 43* S1, pp 37-46.

Wisdom, K., Neighbors, K., Williams, V. H., Havstad, S. L., Tilley, B. C. (2002). Recruitment of African-Americans with type 2 diabetes to a randomized controlled trial using three sources. *Ethnicity & Health 7*, 267-78.

The Invisible Minority: Mental Health Issues of Haitian Adolescents

Guerda Nicolas

Introduction

According to the 2000 census, the increase in the Black American population during the 90s was due more to Blacks emigrating from the Caribbean and Africa than native born African Americans having children. After Jamaica, Haiti is the largest source of Black immigrants to the United States (U.S. Department of Justice, 2000) and the fifth in ranking of documented immigrant sources overall (Zephir, 1996). Despite the increasing number of Haitians in the U.S., the population remains understudied by mental health researchers. The purpose of this study is to describe adolescent mental health and service use patterns for this ethnic group.

For any immigrant population, the transition to a new country, culture and environment can be particularly stressful. Such struggles are often exacerbated by the developmental changes associated with childhood and adolescence. Haitian youth face tremendous physical stressors during their transition to a new country that can be relatively insensitive to their identity development. Adolescents, in particular, may be vulnerable as it is a common practice among Haitians for youth to migrate without immediate family members and to have relatives assume the caretaker role for them, all of which may add to feelings of isolation, conflict of values and loss of the primary support system. As a result of this experience of "traumatic disruption in social and psychological support systems" (Colin, 2001), it is suspected that Haitian immigrant youth will experience mental health problems beyond those of the general African-American youth population (Bibb & Casimir, 1996).

A primary manifestation of this experience is the challenge to racial pride often experienced by Haitian youth upon their arrival to the United States. Even though racial pride is a fundamental aspect of Haitian ethnic identity, this fundamental aspect of the Haitian psyche can be fractured in the transition to America. As an example, note the research of Biafra which suggests that Haitian immigrants are more distrustful of Whites, are generally less racially aware and are less proud of being Black than their African American peers (Biafra, 1993). In the absence of beneficial coping strategies, it is possible that these differences may predispose Haitian youth to a higher prevalence and severity of mental health problems.

Haitian's experienced differential in racial pride upon arrival to the U.S. is thought to be a direct result of their experiences with prejudice and discrimination from both Whites and African Americans upon arrival to this country Further, research suggests that Haitian adolescents face substantial discrimination regardless of their country of origin (Haiti or the U.S.). A 1990 survey of Haitian eighth and ninth graders in South Florida found that over 60% reported having experienced anti-Haitian discrimination in the U.S. (Stepick, 1998). In response to such challenging experiences, many Haitian adolescents resort to (what some Haitian writers refer to as) "cultural suicide" (Stepick, 1998) as a means of assimilating to life in the U.S.

Given the research documenting Haitian adolescent stressors including prejudice and discrimination (Biafra, 1993) and the subsequent variety of mental health difficulties (including depression, alcohol, suicide, gang involvement, etc.) that may arise from the experience of these stressors, an emphasis on understanding prevalence rates, mental health service use, psychiatric illness and treatment is warranted. In addition, given the unmet need in this population of youth, the development of culturally sensitive mental health interventions is necessary. To date, no published research aimed at understanding psychiatric disorders and treatment efficacy for Haitian American adolescents exists. Moreover, there is no published research aimed at improving the mechanisms Haitians use to identify psychiatric symptoms and adhere to treatment. The following study was developed as a means of addressing these mental health service knowledge gaps.

Method

Participants were recruited from a community college in the northeast area (*N* = 26). All were Haitian born individuals who immigrated to the U.S. during childhood, and were a mean age of 10 years old at the time. The average age of the participants was 28 and 50% reported having at least one child. The majority of the participants (94%) reported that their parents were also born in Haiti. The majority of the participants were female (89%) and single (33%). All of the participants were bilingual (English and Haitian Creole) and three of the participants reported speaking a third language (e.g. Spanish). Over half of the participants (53%) reported their income to range from $11,000 to $28,000 per annum while the remainder did not respond to the question. Participants completed the Beck Depression Inventory (Beck, 1961) and Neighborhood and Family Questionnaire (NFQ; Belle, 1981) to examine both quantitative and qualitative aspects of support networks. The majority of the NFQ items were adapted from the Social Networks Interview, designed by Belle and Longfellow (1981). This measure has been used in a number of published studies (Belle, 1981, 1982).

Results

Haitians responses on the BDI were compared to that of African-Americans and the following results were found. No significant differences with regard to overall rate of depression were detected, but there were some significant differences with regard to which items the participants identified as significant. Specifically, Haitian participants were more likely to rate the behavioral aspects of depression higher than the emotional and cognitive items of depression. For example, 39% reported an inability to sleep and 39% reported worrying about their health. Haitian adolescents reported less willingness to seek mental health assistance from a mental health professional and rated their families and friends as their primary source of assistance (Nicolas & Murray, 2002). Seventy-three percent of the participants reported going to their families first for both emotional support (i.e., needing someone to listen, problems with work or partners) and instrumental support (i.e., car problems, financial assistance, etc).

Discussion

Although there is ample evidence documenting the significant role of culture in the occurrence, course and treatment of depression (Oquendo, et al., 2001; Garcia-Alvarez, 1986), few studies have focused on Haitians. The mental health literature in general necessitates an understanding of mental health issues of various ethnic groups in this county. This study helps to bridge that gap by examining research methods and strategies aimed at understanding mental health issues among Haitian adolescents. Given the great concentration of Haitian Americans in Florida, this study should prove timely and relevant for clinicians and researchers.

References

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561-571.

Bibb, A., & Casimir, G. (1996). Haitian families. In McGoldrick, M., Giordano, J., et al. (Eds.). *Ethnicity and family therapy* (2nd ed.). (pp. 97-111). New York: Guilford Press.

Garcia-Alvarez, R. (1986). Epidemiology of depression in Latin America. *Psychopathology, 19* (Suppl 2), pp. 22-25.

Nicolas, G., Murray, J. (2002). *Utilization of mental health services among Haitians*. Paper presented at the American Psychological Association Convention in Chicago.

Oquendo, M. A., Ellis, S. P., Greenwald, S., Malone, K. M., Weissman, M. M., & Mann, J. J. (2001). Ethnic and sex differences in suicide rates relative to major depression in the United States. *American Journal of Psychiatry*, *158*(10), pp. 1652-1658.

Stepick, A. (1998). *Pride Against prejudice: Haitians in the United States*. Boston: Allyn and Bacon.

Zephir, F. (1996). *Haitian immigrants in Black America: A sociological and sociolinguistic portrait* (Ed.). Westport, T: Bergin & Garvey.

U.S. Department of Justice, Immigration and Naturalization Service (2000). *Legal Immigration, Fiscal Year 2000*. Retrieved October 28, 2003, from http://www.bcis.gov/graphics/shared/aboutus/statistics/IMM2000AR.pdf.

Afrocultural Ethos and Mental Health Services: Understanding Behavior in African American Children

Erika D. Taylor

Introduction

Disparities between the mental health outcomes of people of color and Whites in the United States are well documented, and are now a central concern of the U.S. Department of Health and Human Services (see U.S. Department of Health & Human Services [USDHHS], 2001; New Freedom Commission on Mental Health, 2003). The supplement to the Surgeon General's (USDHHS 2001) report on mental health emphasized the importance of examining and improving upon mental health outcomes for people of color. According to the supplementary report, ethnic minorities are less likely to use mental health services and "have less access to mental health services than do Whites. They are less likely to receive needed care. When they do receive care it is more likely to be poor in quality" (USDHHS, 2001, p.3). Although these findings exist, there is little evidence to suggest that ethnic minorities have significantly higher incidences of psychiatric illness.

Diagnoses and treatments that may be inappropriate for people of color further exacerbate their limited access to quality mental health care. For example, some findings suggest that African-American clients are diagnosed accurately less often than White Americans, particularly when suffering from depression or schizophrenia (Borowsky, Rubenstein, Meredith, Camp, Jackson-Triche & Wells, 2000). In addition, studies suggest that African-American clients are more likely to receive more and higher doses of some medications, in spite of findings that suggest that African Americans are more likely to metabolize some medications more slowly. Such findings have been reported for both African-American adults and children (e.g., DelBello, Lopez-Larson, Soutullo & Strakowski, 2001).

There are a number of additional factors (such as practitioner bias, client mistrust, and access to insurance that adequately covers mental health treatment) that contribute to disparities in mental health service delivery. One such factor that contributes greatly to the inappropriate diagnosis and treatment of African Americans is the lack of research on the manifestation and interpretation of psychological symptoms. A number of studies identify using symptom criteria normed on predominately White participants for children of color as a major problem in accurate diagnosis of psychiatric illness, particularly for African Americans (Lambert, Rowan, Lyubansky & Russ, 2002; McNeil, Capage & Bennett, 2002).

Rationale for Study

Taken together, the factors associated with disparities in mental health service delivery present additional challenges for people of color. Specifically, "similar prevalence [of mental health challenges], combined with lower utilization and poorer quality of care, means that minority communities have a higher proportion of individuals with unmet health needs" (USDHHS, 2001, p.3). The lack of quality mental health service presents an especially challenging situation for African Americans.

Specifically, African-American children are disproportionately represented in many youth-serving systems, including special education, juvenile justice and child welfare (Osher, Woodruff & Sims, 2002).

Involvement in such systems increases the likelihood that African American children will be referred to mental health services, as child-serving agencies are the largest source of referrals for mental health treatment (USDHHS, 2001). As a result, African American children are disproportionately exposed to a service delivery system that is ill-equipped to meet their needs. Further, findings suggest that the trajectory from child-serving agencies to the adult penal system (through the juvenile justice system) is common for African American children, particularly males (Osher et al, 2002).

In addition to the lack of research examining psychological symptoms, there is a dearth of research that examines normative behavior for children in any ethnic minority group, including African Americans (McLoyd, 1991). Therefore, additional research on problem behaviors for ethnic minorities would still result in norming those behaviors against criteria for normative behavior that have been developed using research conducted with predominately white children.

The need for additional research on the normative behavior of African American and other ethnic minority children is clear. Increasing the understanding of both normative behavior and mental health phenomena could lead to improved mental health outcomes for African-American children through improved service delivery (i.e., accurate assessment and diagnosis, effective treatment). In turn, improved mental health outcomes for children of color may lead to better overall outcomes for children.

The Present Study

There is evidence to support the notion that culture is an important factor in mental health diagnosis and treatment. In addition, the culture of mental health consumers is identified as key to understanding symptomatology, both in terms of how those symptoms present themselves, and in the way in which consumers make sense of the condition. While some researchers have argued that there is no distinct African-American culture, others contend that African Americans do have a culture, rooted in a common historical experience (Boykin, 1983). Furthermore, many researchers argue that elements of African-American culture can be traced to West African cultures (Nobles, 1991).

This paper reviews the empirical literature using Afrocultural ethos (also known as traditional African ethos) as a framework to understand the behavior of some African American children. Afrocultural ethos is described as a set of guiding beliefs that define a regional communality, largely based in West African philosophy (e.g., Nobles, 1991). These beliefs are reported to be the driving force for emotions, thoughts and behaviors.

Empirical work investigating Afrocultural ethos has examined normative and problem behavior (e.g., Jagers & Smith, 1996), appropriate learning contexts (e.g., Boykin, Jagers, Ellison, Albury, 1997), socioemotional development (Barbarin, 1993; Jagers, 1997), and psychological assessment and treatment (e.g., Neal-Barnett & Smith, 1996). The Afrocultural ethos can be used as a guideline to more accurately diagnose and treat emotional and behavioral challenges among this population.

References

Akbar, N. (1991). The evolution of human psychology for African Ame*ricans*. In R. L. Jones (Ed.) *Black Psychology* (3^{rd} ed). Berkeley: Cobb & Henry.

Barbarin, O. A. (1993). Emotional and social development of African American children. *Journal of Black Psychology, 19*, 381-390.

Borowsky, S. J., Rubenstein, L. V., Meredith, L. S., Camp, P., Jackson-Triche, M., & Wells, K. B. (2000). Who is at risk of nondetection of mental health problems in primary care? *Journal of General Internal Medicine, 15*, 381-388.

Boykin, A. W. (1983). The academic performance of Afro-American children. In J. Spence (Ed.), *Achievement and achievement motives*. San Francisco: W. H. Freeman.

Boykin, A. W., Jagers, R. J., Ellison, C. M. & Albury, A. (1997). Communalism: Conceptualizations and measurement of an Afrocultural social orientation. *Journal of Black Studies, 27*, 409-418.

DelBello, M. P., Lopez-Larson, M. P., Soutullo, , A., Strakowski, S. M. (2001). Effects of race on psychiatric diagnosis of hospitalized adolescents: A retrospective chart review. *Journal of Child & Adolescent Psychopharmacology, 11*, 95-103.

Jagers, R. P. (1997). Afrocultural integrity and the social development of African-American children: Some conceptual, empirical and practical considerations. *Journal of Prevention and Intervention in the Community, 16*, 7-34.

Jagers, R. J. & Smith, P. (1996). Further examination of the Spirituality Scale. *Journal of Black Psychology, 22*, 429-442.

Lambert, M. C., Rowan, G. . Lyubansky, M. & Russ, C. M. (2002). Do problems of clinic-referred African American children overlap with the Child Behavior Checklist? *Journal of Child & Family Studies, 11*, 271-285.

McLoyd, V. (1991). What is the study of African American children the study of? In R. L. Jones (Ed.) *Black psychology* (3rd ed). Berkeley: Cobb & Henry.

McNeil, C. B., Capage, L. C., Bennett, G. M. (2002). Cultural issues in the treatment of young African American children diagnosed with disruptive behavior disorders. *Journal of Pediatric Psychology, 27*, 339-350.

Neal-Barnett, A. M., Smith, J. M., Sr. (1996). African American children and behavior therapy: Considering the Afrocentric approach. *Cognitive & Behavioral Practice, 3*, 351-369.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final Report*. USDHHS Pub. No. SMA-03-3832. Rockville, MD: USDHHS.

Nobles, W. (1991). African philosophy: Foundations for Black psychology. In R. L. Jones (Ed.) *Black psychology* (3rd ed). Berkeley: Cobb & Henry.

Osher, D., Woodruff, D., & Sims, A.E. (2002). Schools make a difference: The overrepresentation of African American youth in special education and the juvenile justice system. In D. J. Losen and G. Orfield (Eds.), *Racial inequity in special education*. Cambridge: Harvard Education Press.

U. S. Department of Health and Human Services (2001). Mental health: Culture, race and ethnicity—A supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: USDHHS, Public Health Service, Office of the Surgeon General.

U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2003). *Child maltreatment 2001* (Washington, DC: U.S. Government Printing Office.

Evidence on Disparities in Mental Health Services for Black Youth

Terri L. Miller

Introduction

Unmet need for mental health services is a substantial problem in the general population and studies indicate poorer quality of care, less access to and utilization of mental health services by people of color despite what is likely to be equal or greater need when compared with other populations. (Kessler et al., 2001; National Advisory, 2001; U.S. Department of Health and Human Services [USDHHS],2001). These findings should be interpreted with caution however, because they are based largely on studies of adults. Evidence documenting the existence of mental health disparities in children and adolescents is relatively scant and somewhat equivocal due to methodological limitations of the research (e.g., failure to report adequate sample demographic information, under-representation of high-need segments of the population, and lack of cross-culturally validated instruments (Snowden, 2001; Weersing & Weiss, 2002). However, findings such as those indicating the recent rapid increases in rates of suicidal behavior among young Black males (Centers for Disease Control and Prevention, 1998) suggest the need for attention to potentially unique patterns of need, utilization, and outcomes in such populations. This paper examines current evidence regarding the existence of disparities in mental health services for Black children and adolescents.

Method

A computerized search of the MEDLINE, PsycINFO, and HealthStar databases covering the period 1985-2003 was conducted to identify publications related to disparities in mental health services for African American youth. Search topics included need for services, access to care, help seeking and referral, engagement and utilization, assessment and diagnosis, and quality and outcomes of care.

Results

Need for services. There have been few community-based studies examining prevalence of mental and substance use disorders (i.e., epidemiologically defined need) in African American youth relative to youth of other racial/ethnic backgrounds. Existing studies have yielded inconsistent results, with some demonstrating no differences and others demonstrating either higher or lower rates of disorder in African American children and adolescents relative to Non-Latino White (NLW) youth (USDHHS, 2001). These inconsistencies could be attributable to methodological variation (e.g., sampling strategies, sample demographic composition, and case finding methods) across studies. As Black youth are disproportionately represented among populations that are likely to be underrepresented in the household or school-based surveys upon which epidemiological studies are most often based (Brunswick, 1997), it is possible that reported prevalence rates represent systematically biased estimates for African American youth.

Access to services. African American youth are disproportionately represented in demographic subpopulations whose access to mental health services is limited due to financial and geographic constraints (USDHHS, 2001). However, a recent review suggests that even when controlling for socioeconomic factors, racial/ethnic disparities in health care between youth of color and NLW youth persist (Elster, Jarosik, VanGeest, & Fleming, 2003). These findings bolster the idea that other factors (e.g., availability of African American and culturally competent providers) are important determinants of access to mental health services for African-American youth, a premise which has been the subject of little formal study to date.

Help seeking and referral. Evidence suggests that African American parents are less likely to (a) perceive their children's difficulties as being "medical" or "behavioral" in nature (Bussing, Schoenberg, Rogers, Zima, & Angus, 1998); (b) view mental health services as potentially helpful for their children

(Takeuchi, Bui, & Kim, 1993); and (c) seek help from traditional/formal mental health providers (McMiller & Weisz, 1996) than their NLW counterparts. Further, African American youth are more likely to be referred for mental health treatment by legal or social welfare agencies, to enter treatment under coercive circumstances (e.g., by court order), and to be incarcerated than their NLW counterparts, who are more likely to be psychiatrically hospitalized despite equal or greater levels of emotional and behavioral disturbance (Bui & Takeuchi, 1992; Takeuchi et al., 1993).

Service engagement and utilization. In general, African American children and adolescents are less likely to receive treatment for mental health problems than NLW youth. However, due to factors including referral patterns (as previously noted) among children who receive services, African-American youth are overrepresented within certain sectors (e.g., juvenile justice, child welfare) and settings (e.g., residential treatment, public facilities) but underrepresented in others (e.g., specialty mental health care, private facilities). Evidence for higher rates of premature treatment termination among African American youth relative to their NLW counterparts is mixed, with some studies supporting such a disparity (e.g., Kazdin, Stolar, & Marciano, 1995) and others not (e.g., Bui & Takeuchi, 1992). Racial/ethnic match between therapist and client has been found to reduce the likelihood of treatment dropout for Black youth (Yeh, Eastman, & Cheung, 1994).

Assessment and diagnosis. Observed disparities in diagnosis across racial/ethnic groups in service settings could be due to actual differences in prevalence of psychiatric disorder, variations in patterns of help seeking and referral, differences in applicability of assessment procedures, or misdiagnosis by clinicians (Yeh et al., 2002). One of the most consistent findings in the mental health disparities literature has been the bias toward the diagnosis of psychotic disorders in African American adults exhibiting similar levels and patterns of psychopathology as their NLW counterparts, who are more likely to receive diagnoses of mood disorders. This finding has been replicated among African American adolescents (Mak & Rosenblatt, 2002), and African American youth have also been found to be more likely to receive diagnoses of disruptive behavior disorders (Fabrega, Ulrich, & Mezzich, 1993).

Quality and outcomes of care. Studies examining disparities in quality and outcomes of care for African-American youth have been limited to date. However, existing evidence suggests that Black youth are less likely than White youth to receive appropriate, evidence-based interventions for mental health problems, such as stimulant treatment for attention deficit hyperactivity disorder (ADHD) (Safer & Malever, 2000).

Discussion

Results indicate limited and equivocal data directly addressing disparities for African American-youth. The most consistent findings suggest that African-American children and adolescents have less access to care, are more likely to be referred for care by external agencies under coercive circumstances, are less likely to enter treatment, are more likely to be assigned diagnoses of psychotic and disruptive behavior disorders despite similar types and levels of psychopathology, and may be less likely to receive effective interventions than NLW youth. This emerging literature base highlights the critical need for methodologically rigorous, culturally relevant research to inform efforts to design and implement more appropriate and effective approaches to the identification and treatment of African-American youth. In particular, it is essential that more attention be devoted to the mechanisms underlying potential mental health disparities for Black youth.

References

Bui, K. T., & Takeuchi, D. T. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*(4), 403-417.

Brunswick, A. F. (1997, May). *Racial differences in surveys of drug prevalence: More than measurement error?* Paper presented at the annual conference of the American Association for Public Opinion Research, Norfolk, VA.

Bussing, R., Schoenberg, N. E., Rogers, K. M., Zima, B. T., & Angus, S. (1998). Explanatory models of ADHD: Do they differ by ethnicity, child gender, or treatment status? *Journal of Emotional and Behavioral Disorders, 6*(4), 233-242.

Centers for Disease Control and Prevention. (1998). Suicide among black youths—United States, 1990-1995. MMWR *Morbidity & Mortality Weekly Report, 47*, 193-195.

Elster, A., Jarosik, J., VanGeest, J., & Fleming, M. (2003). Racial and ethnic disparities in health care for adolescents: a systematic review of the literature. *Archives of Pediatrics & Adolescent Medicine, 157*(9), 867-874.

Fabrega, H., Ulrich, R., & Mezzich, J. E. (1993). Do Caucasian and Black adolescents differ at psychiatric intake? *Journal of the American Academy of Child & Adolescent Psychiatry, 32(*2) 07-413.

Kadzin, A. E., Stolar, M. J., & Marciano, P. L. (1995). Risk factors for dropping out of treatment among White and Black families. *Journal of Family Psychology, 9*(4), 402-417.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36*(6 Pt 1), 987-1007.

Mak, W., & Rosenblatt, A. (2002). Demographic influences on psychiatric diagnoses among youth served in California systems of care. *Journal of Child and Family Studies, 11*(2), 165-178.

McMiller, W. P., & Weisz, J. R. (1996). Help-seeking preceding mental health clinic intake among African-American, Latino, and Caucasian youths. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1086-1094.

National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment. (2001). *Blueprint for change: Research on child and adolescent mental health*. Washington, DC: U.S. Department of Health and Human Services.

Safer, D. J., & Malever, M. (2000). Stimulant treatment in Maryland public schools. *Pediatrics, 106*(3):533-539.

Snowden, L. R. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research, 3*(4), 181-187.

Takeuchi, D.T., Bui, K. V. T., & Kim, L. (1993). The referral of minority adolescents to community mental health centers. *Journal of Health and Social Behavior, 34*, 153-164.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity-A supplement to Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Weersing, V. R., & Weisz, J. R. (2002). Community clinic treatment of depressed youth: Benchmarking usual care against CBT clinical trials. *Journal of Consulting & Clinical Psychology, 70*(2), 299-310.

Yeh, M., Eastman, K., & Cheung, M. K. (1994). Children and adolescents in community health centers: Does the ethnicity or the language of the therapist matter? Journal of Community Psychology, 22(2), 153-163.

Yeh, M., McCabe, K., Hurlburt, M., Hough, R., Hazen, A., Culver S., Garland, A., & Landsverk, J. (2002). Referral sources, diagnoses, and service types of youth in public outpatient mental health care: A focus on ethnic minorities. *Journal of Behavioral Health Services and Research, 29*(1), 45-60.

Symposium Discussion

Alfiee M. Breland-Noble

The presenters addressed three key areas relevant to the inclusion of Blacks/African Americans in mental health services research and the interpretation of findings based on data gathered from this population. Specifically, the presenters addressed (a) sociocultural factors unique to Blacks/African Americans, (b) theoretical and empirical data relevant to racial disparities in the mental health service area, and (c) empirically supported successful strategies for use in recruiting and retaining Blacks/African Americans in mental health related studies.

The theoretical and empirical evidence reviewed in these papers offers strong support for newer methods available to researchers to increase the inclusion of Blacks/African Americans in research. In addition, the literature present empirical data to support psychosocial factors related to unmet mental health need. Such innovative findings add to the current literature focused on financial and diagnostic barriers to care and offer an alternative framework for understanding the origins of some mental health disparities. Future research employing the strategies described may be useful in increasing the numbers of Blacks/African Americans participating in mental health related research and in meeting a mandate of the 2001 Surgeon General's report to decrease unmet mental health need among Black/African American youth.

CONTRIBUTING AUTHORS

Julia H. Bloom, B.A.
Research Assistant, Pediatrics Cincinnati Children's Hospital Medical Center,
3333 Burnet Ave. – MLC #3015, Cincinnati, Ohio 45229-3039, 513-636-3739,
fax: 513-636-7756

Alfiee M. Breland-Noble, Ph.D.
Duke University Medical Center, Box 3527, Durham, NC 27710, 919-416-2432,
fax: 919-416-2420, e-mail: abreland@psych.duhs.duke.edu

Lori E. Crosby, Psy.D.
Assistant Professor of Pediatrics, Cincinnati Children's Hospital, MLC 3015,
Cincinnati, Ohio 45229-3039, 513-636-5380, fax: 513-636-7756

Janelle Hines, B.A.
Research Assistant, Pediatrics Cincinnati Children's Hospital Medical Center,
3333 Burnet Ave. – MLC #3015, Cincinnati, Ohio 45229-3039, 513-636-7817,
fax: 513-636-7756

Terri L. Miller, Ph.D.
Assistant Professor, Department of Psychiatry and Behavioral Sciences, College of
Medicine, Univeristy of Arkansas for Medical Sciences, 4301 W Markhas St. #825,
Little Rock AR 72205, email: millerterrl@uams.edu

Monica J. Mitchell, Ph.D.
Assistant Professor of Pediatrics Cincinnati Children's Hospital Medical Center,
3333 Burnet Ave. – MLC #3015, Cincinnati, Ohio 45229-3039, 513-636-3375,
fax: 513-636-7756

Guerda Nicolas, Ph.D.
Boston College, Lynch School of Education, Campion Hall 305B, Department of
Counseling, Developmental, & Educational Psychology, Chestnut Hill, MA 02467,
617-552-4245, fax: 617-552-1981, e-mail: nicolagu@bc.edu

Erika D. Taylor, Ph.D.
Consultant, 240-274-0428, fax 202-723-6337, e-mail: e.d.taylor@att.net

Constancy and Change in Cultural Competence in Systems of Care

Freda Brashears
Rolando L. Santiago
Gina M. Sgro
John W. Gilford

Acknowledgement: This research was funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (#280-97-8014).

Introduction

As our nation becomes increasingly more diverse, mental health service delivery systems are called upon to serve community members from a wide array of cultural, racial, and ethnic backgrounds. However, many child-serving agencies and systems have not identified or addressed the various structural barriers and value differences that are encountered by ethnic minorities when they attempt to engage with mental health service delivery systems. In response to that unmet need, the Comprehensive Community Mental Health Services to Children and Their Families Program encourages grant-funded communities to develop and implement service delivery systems that are guided by a set of core values, one of which is being cultural competent in organizational structure as well as in direct service delivery.

The system-of-care philosophy or approach developed by Stroul and Friedman (1986) provides guidance to local mental health service delivery systems, or systems of care, in understanding cultural competence as a core value to strive for in both program infrastructure and direct service delivery. In their monograph, the value of cultural competence is described in this way: "Systems of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve" (p. xxiv). Cultural competence, defined as "the state of being capable of functioning effectively in the context of cultural diversity" (p. 3, Cross, Earle, Solie, & Manness, 2000) may be viewed, then, as a goal toward which professionals, agencies, and service systems can strive, indicating that becoming culturally competent is a developmental process (Cross, Bazron, Dennis, & Isaacs, 1989).

As part of the national evaluation of the Comprehensive Community Mental Health Services to Children and Their Families program, a longitudinal study of children's mental health service delivery systems was conducted to determine the extent to which the principle of cultural competence had been applied and the degree to which systems had become culturally competent in both organizational infrastructure and direct service delivery. Progress toward achieving cultural competence was assessed in eight areas that addressed diversity in personnel, staff training, development of the service array, program self-assessment, and the extent to which service delivery was guided by the culturally unique needs of children and families, including providing services in the primary languages of the children and families served.

Method

Nine communities who received 5-year grants from the Comprehensive Community Mental Health Services for Children and Their Families Program in 1997 were included in this study. Three of the communities had multiple program sites so data were collected from a total of 14 local programs during the 5-year grant period of 1997-2002. The communities were geographically located in both urban and rural areas with representation from major regions of the country including Native American tribal communities.

System-of-care assessment data were collected four times on a 12-month cycle during the grant period, beginning in 1999. During 3-day annual site visits to the communities, pairs of trained site visitors conducted approximately 25 separate interviews, reviewed approximately 6 randomly selected case records, gathered information regarding membership of the governing body and case review structures, system-of-care staffing structures, training events provided by the system during the assessment period, funding information, and services available in the service array. Thirteen different semi-structured interview protocols were used to guide the interviews of the respondents who represented multiple perspectives on the local system of care. Respondents included members of interagency governing bodies, project directors, directors of family advocacy organizations, program evaluators, care coordinators, direct service delivery staff such as clinicians, mentors, and behavior specialists, staff from core child-serving public agencies, members of case review committees, and caregivers of children who received services from the system of care.

Administration of the individual, face-to-face interviews varied in length from 45 minutes to 2 hours. Some of the items in the interviews collected contextual or descriptive information and others linked to indicators in the system-of-care assessment conceptual framework. Items linked to framework indicators were scored on a 5-point scale by site visitors. For each interview, items were scored using only information reported by that specific informant and were based on standard criteria. This approach, which based numerical ratings on qualitative data, generated quantitative scores as well as rich descriptive information. Qualitative information was summarized in descriptive narrative reports that also included evaluative information as determined by the quantitative data analysis of the item responses and scoring.

Mean scores derived from ratings of the system-of-care assessment protocol items revealed how well systems of care had applied the cultural competence program principle in the service delivery system domains of system infrastructure and direct service delivery. Longitudinal quantitative data were analyzed to illustrate how well system-of-care communities had implemented the principle over time and qualitative data were analyzed to determine program successes and best practices as well as continuing challenges in meeting program goals related to cultural competence.

Results

In the second year of their 5-year grant period when the first assessment was completed, the grant communities, as a group, scored in the low- to mid-range in both the infrastructure and service delivery domains, then remained fairly constant over the next two years, and by the fifth year, had shown slight improvement in the service delivery area, although the trend was rather flat overall. However, when viewed at the individual program level, no consistent pattern or trend emerged over the five years across the communities or even, for the most part, at the individual community level. Scores varied by community and by domain across the four assessments, with few communities showing a general trend toward goal achievement across time. Rather, there was fluctuation from assessment to assessment and from domain to domain.

A review of the qualitative data revealed that communities operated in fluid and dynamic environments that had unique characteristics as well as a mix of factors that influenced the extent to which the principle of cultural competence could be successfully applied in system infrastructure and service delivery. The qualitative data also revealed that within individual communities and within the operational areas that constitute the system infrastructure and service delivery domains, some innovative and effective efforts had been made to develop culturally competent responses to specific program needs at particular points in time.

Diversity. Across all non-Native American grant communities, the membership of governance boards and case review committees was largely White, non-Hispanic, and female. In Native American grant communities, membership of the governance boards and case review committees was largely American Indian, non-Hispanic and female. Grant-funded staff in non-Native American grant communities also were largely White, non-Hispanic and female. In Native American grant communities, grant-funded staff were largely American Indian, non-Hispanic and female. In all grant communities, the majority of staff was female and the majority of children served was male. In most local programs the racial diversity of the staff approximated the racial diversity of the children and families served. However in some local programs, the majority of staff was non-Hispanic White while the majority of children and families served was African American. These proportions remained fairly constant over time (see Tables 1 and 2).

Table 1
Racial and Ethnic Diversity of Staff and Population Served

Grant Community	Percentage of Staff					Percentage of Population Served				
	AI/AN	A/PI	B/AA	White	Hispanic	AI/AN	A/PI	B/AA	White	Hispanic
1*	0.0	0.0	31.6	68.4	5.3	0.0	0.0	64.9	34.6	1.3
2**	0.0	0.0	0.0	100.0	42.9	4.8	2.4	19.8	47.2	35.9
3*	75.0	0.0	0.0	25.0	0.0	92.2	0.9	0.0	14.8	0.9
4*	0.0	0.0	43.3	56.7	9.1	1.6	0.3	51.3	26.6	19.6
5**	0.0	0.0	0.0	100.0	0.0	2.1	0.9	1.8	83.0	14.2
6**	0.0	0.0	14.3	85.7	0.0	0.0	6.7	17.3	70.7	2.7
7*	0.0	0.0	16.7	83.3	0.0	0.9	3.8	42.1	54.2	7.5
8*	0.0	0.0	0.0	100.0	---	0.9	0.0	60.5	36.0	2.8
9**	90.0	0.0	25.0	75.0	0.0	0.0	0.0	41.6	56.4	3.0
10**	0.0	0.0	0.0	10.0	0.0	98.8	1.2	0.0	1.2	---
11**	0.0	0.0	0.0	100.0	0.0	6.3	0.0	6.3	93.8	0.0
12**	0.0	0.0	0.0	100.0	10.0	4.0	0.0	0.0	92.0	8.0
13**	0.0	0.0	0.0	100.0	0.0	1.4	2.7	0.0	90.5	10.0
14***	0.0	0.0	0.0	100.0	0.0	10.8	0.0	0.0	89.2	9.5

Note: AI/AN = American Indian/Alaska Native; A/PI = Asian/Pacific Islander; B/AA = Black/African-American

Data from most recent complete data set
* 2002 assessment ** 2001 assessment *** 2000 assessment — missing

Table 2
Gender Diversity of Staff and Population Served

Grant Community	Percentage of Staff		Percentage of Population Served	
	Male	Female	Male	Female
1*	36.8	63.2	65.0	35.0
2**	14.3	85.7	67.8	32.2
3*	0.0	100.0	57.4	42.6
4*	24.2	75.8	76.2	23.8
5**	20.	80.0	72.3	27.7
6**	0.0	100.0	63.0	37.0
7*	25.5	74.5	76.6	23.4
8*	0.0	100.0	75.2	24.8
9**	37.5	62.5	69.6	30.4
10**	20.0	80.0	64.3	35.7
11**	0.0	100.0	75.0	25.0
12**	10.0	90.0	60.0	40.0
13**	31.8	68.2	75.7	24.3
14***	40.0	60.0	76.3	23.7

Data from most recent complete data set
* 2002 assessment ** 2001 assessment *** 2000 assessment

Language needs. Across all systems of care and all assessments the most common approach used to meet the language needs of non-English speaking children and families was to access professional interpreters who were available in the community. All communities also reported that they had been successful in recruiting and hiring at least some bilingual or bicultural program staff.

Service planning and provision. All grant communities reported at all assessments that grant-funded staff and service providers addressed cultural considerations in service planning and provision by gathering information about family values, traditions, and beliefs and by using that information to guide service planning and the development of intervention strategies, often accompanied by efforts to link children and families with culturally relevant community services. Information gathering tools varied among respondents and among grant communities from formal and systematic checklists and assessment forms to clinical interview and informal observation or conversation.

Continuing challenges. Systems of care in all grant communities experience continuing challenges in the areas of developing a widely diverse and culturally competent service array that has enough capacity to meet the need, developing local program evaluation efforts to monitor the cultural competence of local systems of care, reaching out to all cultural groups within a community, and in developing objective measurement of culturally competent clinical practice.

Discussion

The results of this study indicate that cultural competence within children's mental health systems of care is not a discrete or static goal that can be defined or achieved easily and maintained as a single construct applied across time, places, and various groups of people. Rather, the "state" of cultural competence is fluid, dynamic, and diverse, perhaps as diverse and complex as the range and magnitude of differences found in all of American society. Implications for policymakers are vast. Development toward cultural competence is an on-going endeavor that will involve continual review and renewal. As changes continue to occur in local community populations and cultures, on-going efforts to deliver culturally diverse and relevant services will be required.

References

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.* (Vol. 1). Washington, DC: Georgetown University Child Development Center.

Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Vol. I.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Stroul, B. A., & Friedman, R. M. (1986). A system of care for children and youth with severe emotional disturbances (Rev. ed.). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

CONTRIBUTING AUTHORS

Freda Brashears, M.S.W.
Research Associate and Project Manager, ORC Macro International, 3 Corporate Square NE, Suite 370, Atlanta, GA 30329, 404-321-3211, e-mail: freda.l.brashears@orcmacro.com

Rolando L. Santiago, Ph.D.
Director for Evaluation and Acting Deputy Chief, Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Suite 11C-16, Rockville, MD 20857

Gina M. Sgro, B.A.
Research Assistant, ORC Macro International, 3 Corporate Square NE, Suite 370, Atlanta, GA 30329, 404-321-3211, e-mail: gina.m.sgro@orcmacro.com

John W. Gilford, Ph.D.
Senior Research Scientist, ORC Macro International, 3 Corporate Square NE, Suite 370, Atlanta, GA 30329, 404-321-3211, e-mail: john.w.gilford.jr@orcmacro.com

Cultural Competence Assessment: A Comparison of Community and Theoretical Conceptualizations

Tamara S. Davis

Introduction

Monitoring development of cultural competence is a critical component of systems of care (Stroul & Friedman, 1986) as mental health services have historically ineffectively addressed the needs of children of color and their families (Hernandez & Isaacs, 1998; Knitzer, 1982). Yet researchers are challenged to find methods for assessing this complex concept. The lack of empirical research delineating definitions, models and impact of culturally responsive practice on mental health inhibits knowledge-based policy and practice development (Cross, Bazron, Dennis, & Issacs, 1989; U.S. Department of Health and Human Services, 2001; U.S. Health Resources and Services Administration, 2001).

This paper presents an evaluative study of cultural competence within a state legislated mental health initiative that included four systems-of-care communities, two urban and two rural. The study's practical evaluative objectives included using an innovative alternative approach to examining cultural competence in an effort to generate baseline system assessments from which further development could be monitored and to assist local and state legislated entities in developing related policy and training plans. The specific knowledge-building aims of the research were to examine the contextual validity of several established models of culturally competent practice within a theory of systems change framework. Specifically, the research sought to explore (1) the extent of differences and similarities in conceptualizations of cultural competence among groups of participants across four systems of care communities, (2) whether the individual and collective community assessments would support current assumptions and theoretical conceptualizations of culturally competent practice, and (3) the viability of the Concept Mapping methodology for conceptualizing and assessing cultural competence in individual communities.

Method

The study's research design attempted to model the systems-of-care value of individualized care by assessing cultural competence from individualized community perspectives. A specialized culturally diverse team comprised of a Family Evaluator, two contracted facilitators, and a Research Associate, was assembled to conduct cultural competence assessments in each community. Representatives from local systems-of-care communities helped plan the assessments.

Sample. The sample included four systems of care communities in Texas, two urban and two rural, all in their second year of development. Each community was responsible for recruiting participants for their individual assessments. The combined participant sample for this study included 188 adults and 34 youth across the four communities. Adult participants in all communities included family members, staff from all levels (from direct care to administration), advisory board members, and providers. Table 1 reflects selected demographics of participants.

Methodology. The study allowed individual community participants to discuss cultural competence from their own perspectives and determine the most significant aspects of cultural competence for their systems of care. Concept Mapping, as developed by Concept Systems, Inc. (Trochim, 1989), was the primary method used for data collection. The method uses a participatory approach to conduct a mixed-method evaluation and was implemented with adult participants. A combined focus group/modified Nominal Group prioritization process was used with youth participants. Separate assessments were conducted for each community.

Data Collection. Qualitative statements were gathered through group processes describing each community's conceptualization of cultural competence. Participants sorted the statements into conceptual groupings, assigned labels to groupings, and then used Likert-type scales to rate each

Table 1
Selected Participant Demographics Across Communities

	Adults		*Youth*	
Category	*N*	*Percent*	*N*	*Percent*
Total Participants	188		34	
Family Member	71	38%		
Non-Family	117	62%		
Gender				
Female	144	77%	14	41%
Male	44	23%	20	59%
Race/Ethnicity				
Asian American	6	3%		
Black/African American	25	13%	4	12%
Mexican American	28	15%	16	47%
White/European	116	62%	12	35%
Other Group	9	5%	2	6%
No Response	4	2%		

statement on two criteria: (1) importance for meeting families' needs, (2) frequency of demonstration within the community's system of care. Non-family members also rated statements on the extent to which they were covered in individual agencies' policies. Finally, participants examined the preliminary results and assisted in data interpretation. Statements from all four communities were combined, reduced to one unduplicated list of statements, and mailed to a sample of the original participants to collect additional ratings for an aggregate examination of the data.

Analysis. Using multivariate statistical techniques, the Concept Systems software produced graphic maps to depict how participants' ideas were related. Participants determined the number and labels of clusters for their respective community map. Statement rating values were used to determine average values for each conceptual cluster. Finally, "pattern match" comparisons were made between participant groups and between rating criteria to produce correlation coefficients indicating consistency between rating patterns. Based on input received during the individual community assessments, the principal investigator produced a synthesized concept map keeping labels as close to the participant data as possible.

Secondary analysis of qualitative data (Thorne, 1994) was then used to compare community conceptualizations with one another and with models of culturally competent practice. Community maps were first compared for common and unique concepts using statements within clusters as a method of clarifying overall thematic meaning of the cluster. To compare results from the individual community and aggregate assessments for congruence with current models of cultural competence, a structured analytic schema was developed using a group relational competence theoretical framework (Davis, 2003; Spitzberg & Cupach 1984, 1987; Spitzberg, 1989). Each practice model's components were embedded into the schema using deductive content analysis with an a priori classification scheme (Franklin, 1996) to ensure theoretical fit. The overall conceptual focus of each community's map was then examined for congruence with the assumptions and emphases of current models of culturally diverse practice.

Results

Conceptual maps were produced for each community reflecting how they viewed the relationship among the data elements. Each community chose the cluster map solution that it believed best represented the participants' ideas of cultural competence. One community selected a seven-cluster solution, two communities selected an eight-cluster solution, and one community selected a nine-cluster solution (see Table 2). Clusters generated in all communities reflect many systems-of-care and wraparound values and principles.

Table 2
Community Cluster Map Labels

	URB-N	*RUR-W*	*URB-E*	*RUR-E*
	(80 statements/ 8 clusters)	(76 statements/ 7 clusters)	(82 statements/ 8 clusters)	(65 statements/ 9 clusters)
A	Respect & Dignity of Client & Family	Provider-Family Respect/Rapport	Empowering & Respecting Families	Mutual Trust & Respect
			Developing Positive/ Trusting Relationships	
B	Family-Driven Service Delivery System	Families as Partners	Family/Provider Partnerships	Family Follow-through & Empowerment
				Family Barriers
C	Characteristics of Effective Agencies	Good Service Practices	Characteristics of Quality Services	Service Accessibility
			The Role of the Service Provider	
D	Local Service Policy Implications	Positive Interagency Interaction	Continuity of Care	Enhancing Policy to Facilitate Collaboration
E		Responsive to Family Uniqueness	Individualized Services	Meeting Individual Family Needs
			Family-Focused Services	Providers Embrace Family Culture
F	Changes in System Services with Needs of Consumer	Culturally Responsive Services		To Prevent Cultural Barriers
G	Quality Assurance of System of Care Reform	Positive Measurable Progress		
H				Children's Rights
I	Responsive Resource Allocation Policies			
J	Cultural Competence: Staff & Training			

Average cluster ratings for the three criteria listed above, resulting from the individual data element ratings, were used to develop comparison maps and pattern matches between groups of participants. Two specific group comparisons were made for each community: (1) Family and Non-Family participants, and (2) People of Color and White/European participants. Other group comparisons were made depending on the particular requests and needs of communities. Differences between group ratings were found on each criterion; however, the extent of the differences varied across communities. Comparisons were also made between ratings of importance and demonstration. These pattern matches offered communities an overall baseline from which to monitor their cultural competence development over time.

To assist the State oversight committee in developing training and technical assistance resources for all systems of care communities, data elements from each community were compared to identify common and unique examples of cultural competence across communities. Of the 303 statements originally generated across communities, 117 individual statements were identified during the data reduction process. Of the 117 statements, four were common across all communities, 20 were common to three communities, 44 were common to two communities, and 49 were unique to individual communities.

The model comparisons found that overall a number of elements of each practice model compared were identified across the systems-of-care community conceptualizations of cultural competence. However, the extent to which each model's elements were included varied by community. In contrast, a number of the individual practice model's elements were not included in the individual community conceptualizations, including some critical assumptions of the models.

Summary

Conceptualization of cultural competence requires individualization at the family, organizational, and community levels. The Concept Mapping methodology offers a unique way of gathering and analyzing data from many individuals across multiple levels of systems of care. By examining the discrepancies between participant ratings, the results of the study will help participating systems of care develop technical assistance and training plans that meet their unique needs. Moreover, the assessment established a baseline for each community that can be used to monitor communities' progress in developing culturally competent systems of care. Results from the aggregate data can assist the State team in planning resource development. On a broader scale, the methodology used for this study demonstrated great promise as an alternative to conceptualizing and assessing the complex value of cultural competence in children's mental health systems of care. Mixed results were found in the practice model and systems of care conceptual comparisons, whereby no one model of practice wholly accounted for all of the concepts generated by the systems of care communities. Finally, the group relational competence framework provided a useful structure within which to make the comparisons and offers a promising framework for the development of a comprehensive relational theory of cultural competence.

References

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Toward a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Davis, T. S. (2003). Viability of Concept Mapping for Assessing Cultural Competence in Children's Mental Health Systems of Care: A Comparison of Theoretical and Community Conceptualizations (Doctoral dissertation, The University of Texas at Austin, 2003) *Dissertation Abstracts International, in press.*

Franklin, C. (1996). Learning to teach qualitative research: Reflections of a quantitative researcher. In M. B. Sussman & J. F. Gilgun (Eds.), *The methods and methodologies of qualitative family research* (pp. 241-274). New York: The Haworth Press.

Hernandez, M., & Issacs, M. R. (1998). *Promoting cultural competence in children's mental health services.* Baltimore, MD: Brookes.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services.* Washington, DC: Children's Defense Fund.

Spitzberg, B. H., & Cupach, W. R. (1984). *Interpersonal communication competence*. Beverly Hills, CA: Sage.

Spitzberg, B., H., & Cupach, W. R. (1987). *The model of relational competence: A review of the assumptions and evidence*. Paper presented at the Speech Communication Association Conference.

Spitzberg, B. H. (1989). Issues in the development of a theory of interpersonal competence in the intercultural context. *International Journal of Intercultural Relations, 13*, 241-268.

Stroul, B. A. & Friedman, R. M. (1986). *A System of care for children and youth with severe emotional disturbances*. (Revised edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Thorne, S. (1994). Secondary analysis in qualitative research: Issues and implications. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 263-279). Thousand Oaks, CA: Sage.

Trochim, W. M. K. (1989). An introduction to concept mapping for planning and evaluation. *Evaluation and Program Planning, 12,* 1-16.

U. S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity-A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U. S. Health Resources and Services Administration. (2001). *Health Resources and Services Administration study on measuring cultural competence in health care delivery settings: A review of the literature.* Washington, DC: Office of Minority Health.

CONTRIBUTING AUTHOR

Tamara S. Davis, Ph.D. M.S.S.W.

Post-doctoral Fellow, Hogg Foundation for Mental Health, The University of Texas at Austin, 3001 Lake Austin Blvd., Austin TS 78703, 512-471-5041, fax: 512-471-9608, e-mail: tsdavis@mail.utexas.edu

Differences Between Urban and Rural Cultural Competency Issues in Missouri

Paul Thomlinson
Connie Maples
Aaron Rimel

This research was funded by the Substance Abuse and Mental Health Services Administration (SM-02-002 CMHS Child Mental Health Initiative 93-104).

Introduction

Cultural competence (CC) in the context of systems of care has been defined as "a set of congruent behaviors, attitudes, and policies that come together in a system…and enable that system…to work effectively in cross-cultural situations" (Cross, 1988). Achievement of relatively more CC is viewed as a means to eliminate disparities in mental and physical health status among distinct sub-populations (Chambers, et al., 1998); as such, systems of care (SOC) are naturally interested in the benefits of a CC self-assessment process (Goode, Jones & Mason, 2002).

One of the major challenges presented to the *Show-Me Kids* SOC site, located in a six-county region of the southwest Missouri Ozarks, is addressing the CC of partner agencies serving the third largest metropolitan area in the state, as well as some of the most remote and sparsely populated areas of the state. Added to this challenge is the very recent, explosive growth of the Hispanic population, especially in rural counties in the region.

Many reasons exist for the lack of parity between rural and urban areas with respect to availability of mental health services. Some reasons include a shortage of trained professionals, limited service delivery and support services, lack of health insurance, the cost of providing services, and the stigma of seeking mental health services among some subgroups (Rural Mental Health Providers Workgroup, 1997). Thus, cultural issues are certainly contributing factors, and include cultural nuances and contextual factors such as lack of childcare and time conflicts (Pedersen, et al., 2002).

Based on these issues, the Show-Me Kids coalition decided to systematically examine the self-assessed level of CC in the region, and to look for differences between the urban and rural partners that might be helpful in development efforts. Hence, two basic research questions emerged from this project: (1) What is the baseline level of perceived CC among child-serving agencies in a first year CMHS funded SOC site? and (2) Are there significant differences between rural and urban partners with respect to specific areas of CC?

Method

Survey participants included representatives from all Show-Me Kids stakeholder groups, and data were collected at three large regional SOC cross-training events. Specifically, the 432 survey respondents were comprised of mental health agency workers, educators from area public schools, juvenile justice workers, parents, children's services staff, and representatives from the state Department of Mental Health. Two school districts, one rural and one urban, elected to use the survey with all their staff, contributing 227 surveys. With 40 school districts to be potentially represented, the school surveys were adjusted to represent a more accurate picture by randomly selecting five surveys from this pool of 227 district surveys, two from the rural district and three from the urban district, and adding them to the 28 school surveys collected at the cross-trainings (see Table 1).

Table 1
Survey Participants

Agency	*Total # Surveys*	*Adjusted # Surveys*	*Rural*	*Urban*
MH Providers	60	60	20	40
Schools	255	33	11	22
DMH	36	36	16	20
Social Services	48	48	19	29
Juvenile Justice	20	20	5	15
Others	13	13	5	8

The Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth with Special Health Needs and their Families (hereinafter, "the Checklist;" Goode, 2002) is a 32-item questionnaire intended to heighten awareness and sensitivity to the importance of cultural diversity and CC in human service settings, while also serving as a tool to assess these competencies. The Checklist provides a three point response scale (1 = *Things I do rarely or never*; 2 = *Things I do occasionally*, 3 = *Things I do frequently*), assessing three main domains of CC: (a) physical environment, materials, and resources; (b) values and attitudes; and (c) communication styles.

Procedure. The six counties were divided into two groups based on population density to form rural and urban subgroups. The questionnaire results were analyzed using independent samples *t*-tests, comparing urban and rural partners' ratings on each item, subscale and total of the Checklist. Multiple *t*-tests were employed, using the Bonferroni correction procedure due to the large number of comparisons.

Results

Valid surveys were collected from 210 participants. A sufficient number of surveys were available to analyze differences related to rural/urban status (*n* = 76 and *n* = 134, respectively). Our stakeholders decided items with means of less than 2.0 (*Things I do occasionally*) should be considered as areas of opportunity for review. Analysis showed that urban partners reported means of less than 2.0 on the same eight items from the Checklist as did the rural partners. Rural partners reported one additional mean (i.e., Other Media) below 2.0, for a total of nine items. It is interesting to note that both rural and urban partners identified the same challenges (see results in Table 2).

Individual averages were collected in rural or urban accumulators for each subscale or the total, and divided, respectively, by the number of rural or urban participants. Results indicated no significant differences between the rural and urban groups on the overall Checklist average score. However, one of the three subscales averages, Physical Environment and Materials, was significantly lower for rural participants (see Table 3).

Table 2
Items of Opportunity

Item Description	*Item #*	*Rural Mean*	*Urban Mean*
Display/décor	1.	1.77	1.97
Printed material	2.	1.59	1.75
Other Media	3.	1.74	
Bi-lingual interpretation	6.	1.95	1.95
Use of other language	7.	1.83	1.97
Written in first language	9.	1.99	1.92
Abreast health issue	26.	1.84	1.82
Abreast best practices	28.	1.73	1.66

The differences in responses between rural and urban providers, for the most part, were negligible. Approximately one third of the questions were rated higher for rural and two thirds of the questions were lower or equal to the urban respondent when analyzed individually. Three of the 32 items were statistically significantly lower (p = .05) for the rural participants (see Table 4). Those items were:

- **Item # 1:** I, or my agency, display(s) pictures, posters, artwork, and other décor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.
- **Item # 3:** When using videos, films, or other media resources for health education, treatment, other interventions, I, or my agency, insure(s) that they reflect the cultures and ethnic backgrounds of individuals and families served by my program or agency.

Table 3
Results for Total and Subscale

Checklist Scale		*Mean*	*SD*	*t*	*p*
Total Survey	Rural	2.35	.292	-1.530	.064
	Urban	2.42	.280		
Physical Environment	Rural	1.72	.586	-1.841	.034
Materials Subscale	Urban	1.88	.586		
Communication Style	Rural	2.35	.445	.230	.410
Subscale	Urban	2.34	.420		
Attitudes & Values	Rural	2.50	.321	-.505	.307
Subscale	Urban	2.52	.280		

- **Item # 12:** I, or my agency, screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.

Discussion

A review of the literature revealed a need for further research in the differences in cultural competency among the populations of varying density, i.e., rural vs. urban areas. Our site offers a unique opportunity to contrast the experience of rural and urban populations within one SOC. The results of this self-assessment have provided stakeholders with a snapshot of their relative positions along the continuum of cultural competency. Although this report focuses on the scores of all the partners, results of specific interest and value to our partners were the results within agencies providing services to rural and urban areas (i.e., child welfare offices based in city and rural settings).

Survey feedback can be a powerful organizational or systems change tool, as participants grapple with the issues that are raised through analysis of the results. For example, what might explain significant differences between rural and urban participants with respect to their agencies' physical décor/artwork display, the use of media/video resources and printed materials reflective of ethnic/cultural communities? Several possible explanations might emerge for lower scores in rural areas. Lack of awareness or exposure to information about the presence of growing Hispanic enclaves in rural counties may contribute to a status quo mentality. Given that the major influx of persons of Hispanic ethnicity is very recent and specific to communities offering employment, some communities remain almost wholly homogeneous. A 2001 survey of Hispanics/Latinos in this area found that 53% of the participants had been here for three years or less and that most of these people were from other countries (Wirth, 2001). Additionally, poorer economic conditions in certain predominantly rural counties may contribute to a lack of media resources, art, and décor reflective of minority cultures. It is also plausible that concerns about offending members of a particular culture might be a factor in keeping offices sterile and neutral.

In a more general analysis of needs from the survey, the use of bilingual interpreters and materials printed in the language of origin was identified as a concern in both rural and urban areas. This is in keeping with reports that only 38% of Hispanics in the area report they speak English well (Wirth, 2001). Keeping abreast of ethnic/cultural health issues and of best practices also emerged as concerns. The homogeneous White population in the area makes contact with persons from other cultures a relatively rare occurrence (U.S. Census Bureau, 2000). It is hoped that the results of this survey will be helpful in identifying and clarifying the need for building networks and effectively utilizing resources in each county to address newly emerging cultural issues, as this approach is at the heart of the philosophy underlying systems of care. It is also hoped that these survey results can be helpful to other systems of care that are relevantly similar as they confront issues of cultural competency.

Table 4
Results for Checklist Items Showing Statistical Significance

Checklist item		*Mean*	*SD*	*t*	*p*
Display / décor	Rural	1.77	.768	-1.732	.043
	Urban	1.97	.803		
Other media	Rural	1.74	.712	-3.281	.001
	Urban	2.11	.803		
Screen stereotypes	Rural	2.00	.811	-1.695	.046
	Urban	2.20	.826		

References

Chambers, E. D., Siegel, C., Aponte, C., Bank, R., Blackshear, R., Chow, J., Grantham, R., & Haugland, G. (1998, September). *Cultural competence performance measures for managed behavioral healthcare programs*. The New York State Office of Mental Health & The Research Foundation for Mental Hygiene. Report Available from SAMHSA or NYS Office of Mental Health.

Cross, T. L. (1988). *Cultural competence continuum*. Focal Point (Fall Bulletin). The Research and Training Center on Family Support and Children's Mental Health, Portland State University. Portland, OR.

Goode, T.D. (2002), *Promoting Cultural Diversity and Cultural Competency Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth with Special Health Needs and their Families*. Georgetown University Center for Child and Human Development-University Center for Excellence in Developmental Disabilities Education Research and Service. Adapted from – *Promoting Cultural Competence And Cultural Diversity In Early Intervention And Early Childhood Settings* – June 1989. Revised 1993, 1996, 1999, 2000, & 2002.

Goode, T., Jones, W., & Mason, J. (2002). *A Guide to planning and implementing cultural competence organizational self-assessment*. Washington, DC: National Center for Cultural Competence. Georgetown University Child Development Center. University Center for Excellence in Developmental Disabilities.

Pedersen, P., Draguns, J., Lonner, W., & Trimble, J. (Eds.). (2002). *Counseling across cultures* (5th ed.). Thousand Oaks, CA: Sage.

Rural Mental Health Provider Work Group (1997). *Mental health providers in rural and isolated areas*. Washington, DC: U.S. Department of Health and Human Services.

United States Census Bureau. (2000).State and County Quick Facts: Author. Available at:http://www.census.gov/main/www/cen2000.html

Wirth, J. (2001). *The story of the Hispanic/Latino experience in Southwest Missouri: Surveys of Latino adults, Latino youth, and non-Hispanic services providers/community residents*, University of Missouri Outreach & Extension. Available at: http://www.mo-rivers.net/Hispanic_Latino/Cambio_ deColores.htm

CONTRIBUTING AUTHORS

Paul Thomlinson, Ph.D.
Vice President, Research and QA, Burrell Behavioral Health,
1300 Bradford Parkway, Springfield, MO 65804, 417-269-7242,
fax: 417-269-7212, e-mail: Paul.Thomlinson@Coxhealth.com

Connie Maples, M.S.
Senior Evaluator, Burrell Behavioral Health, 1300 Bradford Parkway,
Springfield, MO 65804, 417-269-7495, fax: 417-269-7212,
e-mail: Connie.Maples@Coxhealth.com

Aaron Rimel, B.S.
Evaluator, Burrell Behavioral Health, 1300 Bradford Parkway,
Springfield, MO 65804, 417-269-0409, fax: 417-269-7212