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

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Advocates' FORUM

2004

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MISSION STATEMENT

Advocates' Forum is an academic journal that explores clinical implications, social issues, administration, and public policies linked to the social work profession. The journal is written, edited, and created by students of the School of Social Service Administration, and its readership includes current students, alumni, faculty, fieldwork supervisors, and other professionals in the field. The editors of *Advocates' Forum* seek to provide a medium through which SSA students can conribute to the continuing discourse on social welfare and policy.

EDITORIAL POLICY

Advocates' Forum is published by the students of the School of Social Service Administration at the University of Chicago. Submissions to the journal are selected by the editorial board from works submitted by SSA students and edited in an extensive revision process with the authors' permission. Responsibility for the accuracy of information contained in written submissions rests solely with the author. Views expressed within each article belong to the author and do not necessarily reflect the views of the editorial board, the School of Social Service Administration, or the University of Chicago. All inquiries and submissions should be directed to:

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School of Social Service Administration
The University of Chicago
969 East 60th Street
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ESSAYS AND ARTICLES

DISSERTATION ABSTRACTS

ON THE COVER

GROWTH by C. Marks
School of Social Service Administration, The University of Chicago
Photographer: Patricia Evans

The motto of the University of Chicago states, "Crescat scientia; vita excolatur," which translates to, "Let knowledge grow from more to more; and so be human life enriched." Here at the School of Social Service Administration, the educational emphasis is no different; students develop their analytic skills and increase their knowledge base. Both are crucial to determining and implementing social interventions, be they at the clinical or macro level. *Advocates' Forum* continues to raise its standards by putting forth an exceptional academic journal for students of social work. In these pages, writers express informed opinions, grounded in argumentation and evidence, about pressing social issues. This year, the editorial board has put into place a "peer review process," which is a central feature of most academic journals. This method of editorial review has allowed this year's authors to hone their analytic, research, and writing skills. Another addition we have made to the journal is to publish the dissertation abstracts of doctoral students, so that our readership can be better informed about the research taking place in doctoral study. Finally, we have instituted a year-long submission policy, so that graduating masters students are able submit work from their last quarter at SSA for publication after graduation.

This year, we saw a dramatic increase in the number of submissions for publication. This has made the final selection of articles challenging, but at the same time stimulating. We are pleased to offer to our readers a volume that captures both the diversity of the social work profession and the diversity of interests of the students at SSA. This compellation of articles touches upon a wide range of current topics. Suzanne Roth's piece on undocumented students and education policy is a timely exploration of the increasingly critical issue of immigrants' rights. Marius Dancea presents a compelling look at microenterprise programs in disadvantaged communities. In her article, Beth Tapper evaluates the conversion of hospitals from nonprofit to for-profit, examining various policy prescriptions for

this growing trend. Elizabeth Bowen offers a clinical examination of cultural competency in mental health care. Alana Gunn's article provides an intimate discussion on incarcerated mothers and adolescent development. Finally, Meegan Bassett contributes a cross-cultural discussion of chronic poverty's impact on adolescent development in the United States and South Africa.

In putting together this volume of *Advocates' Forum*, our aim is to present a compelling look at diverse topics from both the policy and social work practice perspectives. We hope the journal will continue to inform our readers while actively contributing to the greater body of academic discussion within the social work profession. From our hands to yours... we hope you will enjoy reading this year's volume.

Paulette Yousefzadeh
Alexis Jaeger
CO-EDITORS IN CHIEF

The editorial board of *Advocates' Forum* wishes to thank Virginia Parks, Ph.D., faculty advisor, Andrea Durbin-Odom, director of communications at SSA, and Christopher Leiker, copy editor of *Advocates' Forum*, for all their efforts and invaluable input in making this year's volume. Virginia has helped the editorial board raise the bar in our review and selection of articles for this year's publication. Andrea has been instrumental in coming up with fresh ideas for the journal and providing strong administrative support. Last, but certainly not least, Christopher has put in many, many hours in editing students' submissions, providing highly thoughtful and detailed feedback.

ABOUT THE EDITORIAL BOARD

ELIZABETH BOWEN is a second-year clinical student at the School of Social Service Administration, specializing in older adult studies. She is a graduate of the University of Pittsburgh, where she majored in psychology and nonfiction writing. Currently an intern in the Department of Psychiatry at the University of Chicago Hospitals, Elizabeth hopes to work with elderly people following graduation. Her social work interests include aging and mental health, cultural competency, religion and spirituality, and international social work.

LEKESHA CAMPBELL is a third-year joint degree student at the School of Social Service Administration and the Harris School of Public Policy Studies. She has worked as an instructor and mentor for school-aged children, as a therapist for drug-addicted adults, and currently does policy research on early-childhood care and education issues. Her interests include work with low-income populations, with concentrations in family support, child and family policy, and education policy reform. She is a recipient of the Brinks Family Support Fellowship and the McCormick Tribune Child and Family Fellowship. Lekesha graduated from the University of Pennsylvania and received a B.A. in sociology in 2001.

HEATHER FRASER is a second-year clinical student at the School of Social Service Administration. She graduated from Ohio University with a B.A in sociology and minors in psychology and women's studies. Heather is currently an intern at Womencare Counseling Center. Heather's clinical interests include feminist therapy, community mental health, domestic violence, and work with families affected by trauma.

SHELBY FRENCH is a second-year clinical student at the School of Social Service Administration, focusing on trauma work with children and adolescents. She holds a B.A. in international relations from San Francisco State University (SFSU), and a master of science degree in international development from the School of Oriental and African Studies at the University of London. Previously, Shelby was a writer and associate editor for the *International Relations Journal*, published by SFSU. She is currently the coordinator for CARE Corps, an international volunteer program. Upon graduation, Shelby will begin working at the Center for Contextual Change, primarily with clients who have experienced trauma and violence.

MATTHEW HAYDEN is a first-year clinical student at the School of Social Service Administration, with an interest in mental health counseling. A native of Buffalo, NY, he received a B.A. in English and a B.Mus. in vocal performance from Oberlin College, as well as an M.Mus. in voice from the University of Akron. Prior to coming to SSA, he worked at a Planned Parenthood Clinic and a refugee services organization, and volunteered with an LGBT youth center and a rape-crisis hotline. He also worked in higher education administration and continues to teach and perform music professionally.

ALEXIS JAEGER is a first-year clinical student at the School of Social Service Administration. Prior to attending SSA, she worked as a housing organizer with federally subsidized Section 8 tenants in New York City. Alexis would like to continue working with issues of housing and homelessness in the future. She graduated from the University of Wisconsin–Madison with a bachelor's degree in English.

MICHELLE MILLS is a second-year master's student at the School of Social Service Administration and is also in the Graduate Program for Health Administration and Policy. She currently works as an intern with the Health and Medicine Policy Research Group, a nonprofit organization committed to research and advocacy around health policy issues for poor and underserved populations. She has also continued her work with domestic violence survivors while at SSA. She holds a B.A. in anthropology from Indiana University. She hopes to combine her interests in women's issues, health, and politics in her future work.

F. GRACE AIR SOLARES is a first-year student concentrating in school social work. Prior to attending the School of Social Service Administration, Grace was a classroom teacher and Outstanding Scholar at the U.S. Department of Education, where she had principal responsibility for several national secondary education initiatives. She graduated with honors from Smith College, earning a B.A. in French studies and secondary education. Upon graduation, Grace hopes to pursue her interests in comprehensive school reform and children's mental health.

AMY THERIAULT is a first-year student at the School of Social Service Administration and is also a member of the Graduate Program in Health Administration and Policy. Her interests include the issues of mental health, homelessness, the provision of health services, and health outreach. She graduated from Hood College with a bachelor's degree in social work. Upon graduation, Amy hopes to work in health administration with a focus on meeting the needs of underserved populations.

PAULETTE YOUSEFZADEH is a joint masters and doctoral student at the School of Social Service Administration, and will graduate from the masters program in 2004 with a social administration concentration. Her research interests include human trafficking, women's human rights, immigrant and refugee populations, and international social work. She currently works as a research associate at Heartland Alliance, Mid-America Institute on Poverty. Prior to attending SSA, Paulette received a Predoctoral Intramural Research Training Award (IRTA) Fellowship at the National Institutes of Health. She graduated with college honors from Washington University, earning a B.A. in psychology.

Undocumented Immigrants and Higher Education: A Call for Federal Change

By Suzanne Roth

Thousands of undocumented immigrants graduate from high school every year. Because of their immigration status, these students often find it difficult or impossible to gain college admission and subsequent financial aid. This article contends that federal policies should be changed to allow undocumented students access to financial aid programs and the opportunity to apply for legal citizenship status. Current federal policies are contradictory concerning undocumented immigrants and, as a result, society is unable to fully benefit from the contributions that this population could make to the United States.

Sixty-five thousand undocumented immigrants graduate from high school in the U.S. every year (Argetsinger and Aizenman, 2003; Passel, 2003; National Immigration Law Center, June 2003). At graduation, these students have lived in the United States for at least 5 years (Argetsinger and Aizenman, 2003; Passel, 2003; National Immigration Law Center, 2003*c*). These students face the harsh reality that they may not be permitted to attend college and, if admitted, financial limitations may prevent them from attending (Suárez-Orozco and Suárez-Orozco, 2002). Current federal policies are contradictory with regards to undocumented immigrants. This is evidenced by the fact that this country recognizes the rights of undocumented children to a public education until they graduate from high school, but after that time, they are currently no longer entitled to educational opportunities. Changes to current federal policies should be implemented to ensure that society is able to fully benefit from the potential contributions of these students. Undocumented students should be allowed to access financial aid programs and to apply for citizenship. If implemented, such changes could have a universal and lasting impact on both undocumented students and the American system of higher education.

UNDOCUMENTED STUDENTS IN THE UNITED STATES

Undocumented students face unusual and complicated circumstances. They are typically acculturated to American society, have lived in this country most of their lives, speak English, consider themselves Americans, have succeeded in school, and are culturally competent in American customs, but are not fully members of society because of their immigration status (Suárez-Orozco and Suárez-Orozco, 2002). Further complicating their situation is the fact that many of these students were brought to this country through no choice of their own and at a very young age. The United States is the only home they have ever really known. In addition, it is not uncommon for these students to have siblings who were born in the United States. This creates divided families; some family members are citizens, others remain undocumented. The complex experiences of these students can cause them great distress, as no area of their life is entirely stable. The overall experiences of undocumented children can be characterized by high levels of stress, anxiety, tension, fear, hopelessness, and depression (Hunter and Howley, 1990; Suárez-Orozco and Suárez-Orozco, 2002).

Undocumented students graduating from high school are typically unable to attend public colleges and universities at in-state tuition rates. Undocumented students are also denied access to federal student loan programs and federal grants. Because they have no immigration status, they are also prevented from applying for grants and scholarships related to academic achievement and socioeconomic status. While policies do vary by institution and there are exceptions across the country, many colleges will not even process an application without a Social Security number. Such policies immediately disqualify an undocumented student, regardless of his or her ability to pay tuition. In five states, California, Texas, New York, Utah, and Illinois, undocumented students have been granted the right to attend and pay in-state tuition at public colleges and universities; however, these changes only partially solve the problem at hand. Upon graduating from college, the options available to these students are extremely limited because undocumented students are not legally able to work in this country.

There are innumerable personal accounts of undocumented students who earned good grades, worked hard in school, and were involved in extracurricular activities, but could not attend college (Alien status an unfair block, 2003). When these students graduate from high school, they are unable to take the next step that would be encouraged or expected if they were U.S. citizens. The stories of Tania Unzueta and Miguel Parra (Puente, 2001) illustrate

the hardships faced by undocumented students residing in the United States. Both are eager to see changes in the current laws regarding higher education. In the following account, Tania's story is similar to that of many undocumented students graduating from high school.

> Tania Unzueta is a swim team captain who plays the clarinet and piano and listens to hip-hop and rock music. One Saturday, she graduated from a Chicago high school with a year of college credit earned from Advanced Placement tests.... Her family left Mexico when she was a young girl, and she is still not a legal resident of the United States.... (Puente, 2001, p. B1).

Like Tania, Miguel is by all accounts a typical graduating senior; however, his immigration status sets him apart from the rest of his classmates. That status directly affects his educational options after he graduates from high school.

> Miguel Parra, 18, an undocumented immigrant and senior at a suburban high school, said his parents can't help him pay for college.
>
> His father, who works in a restaurant, barely earns enough to pay the family's bills. Legally, Parra can't work to pay for his own tuition.... Parra's family immigrated to the U.S. when he was 11.
>
> At home, his bedroom wall is decorated with scholastic honors. Parra is in the National Honor Society and a captain on the track and cross-country teams (Puente, 2001, p. B1).

Federal legislation allowing these students to seek financial aid and apply for citizenship status would give them the opportunity to realize their full potential and reward them for their hard work and efforts during high school. These students have succeeded in the face of adversity. They should be rewarded for their hard work and given the same opportunities as their peers. Federal legislation may offer solutions.

FEDERAL AND STATE LEGISLATION: A MOVE IN THE RIGHT DIRECTION

Current U.S. immigration policies are inconsistent with regard to undocumented immigrants, especially in the case of these students. *Chicago Tribune*

columnist Don Wycliff (2002) notes that there is a lot of "winking" going on in the United States with respect to undocumented immigrants (p. A23). While the United States condemns illegal immigration and imposes harsh penalties on those who break the laws, the parents and relatives of undocumented children are permitted to work and subsequently pay taxes. Yet, the United States does not allow the undocumented children of these taxpayers to be full participants in American society.

During the past few years, a contentious debate has raged at the federal and state levels over undocumented students and access to higher education. In 2001, federal legislation was introduced to address these issues. In the Senate, the Development, Relief, and Education for Alien Minors (DREAM) Act (S. 1291, 107th Congress) was sponsored by Senators Orrin Hatch (R-UT) and Richard Durbin (D-IL). The legislation's purpose was to amend the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (Public Law No. 104-28). The DREAM Act would grant amnesty to undocumented students who have resided in the U.S. for at least 5 years, graduated from high school, and displayed good moral character (National Immigration Law Center, 2003*b*). In addition, immigrants benefiting from the act would be at least 12 years old on the date of enactment and under 21 years old at the time they apply for relief (National Immigration Law Center, 2003*b*). The DREAM Act would also permit states to determine residency for higher education purposes and offer long-term resident immigrants the opportunity to pursue legal immigration status (National Immigration Law Center, 2003*b*).

In the House of Representatives, the Student Adjustment Act (H.R. 1918, 107th Congress) was sponsored by Representatives Chris Cannon (R-UT), Howard Berman (D-CA), and Lucille Roybal-Allard (D-CA). This resolution was a companion to the DREAM Act and was similar in its restoration of states' rights to determine residency for purposes of higher education benefits. The Act would also offer immigration relief to long-term resident students of good moral character and enable students applying for immigration relief to obtain federal grants and loans on the same basis as other students possessing legal citizenship status (League of United Latin American Citizens [LULAC], 2002; National Immigration Law Center, 2003*a*).

Both the proposed DREAM Act and Student Adjustment Act were gaining support in Congress until September 11, 2001. After that date, American immigration policies became more restrictive. Advocates continue to refer to these proposals when discussing undocumented students and higher education because these initiatives have facilitated dialogue and heightened public awareness on this issue. In addition, the bipartisan sponsorship of, and support for, these proposals sent a strong message to Americans and members

of both parties. The proposed legislation emphasized that both parties recognized and were responding to the needs of immigrants, especially to those of undocumented youth.

At the state level, California, New York, Texas, Utah, and Illinois have passed legislation allowing undocumented students to pay in-state tuition at public universities. In Illinois, Governor Rod Blagojevich signed House Bill 60 into law on May 20, 2003 (Public Act 93-007). This legislation permits undocumented students to be classified as Illinois residents for the purpose of in-state tuition if they graduated from an Illinois high school and have resided in Illinois for at least 3 years (Jervis, 2003*a*). Such legislation regarding undocumented students has been passed in states with the highest populations of immigrants. Nevertheless, most states lack such laws. The issues of undocumented students should therefore be addressed in a way that protects such students in all states, nationwide. In spite of these advances in a few states, changes at the federal level are the only way to ensure the consistency of policies that will nationally protect the rights of immigrants (Blank, 1997). Furthermore, as proven through past immigration reform, the federal government possesses the capability to administer and monitor such policies (Blank, 1997; Weissbrodt, 1998).

FEDERAL POLICY CHANGE: THE TIME IS NOW

While state legislation is a move in the right direction, it is problematic; the problem is only partially solved by granting undocumented students the right to attend public universities and to pay in-state tuition. Regardless of state residency provisions, once these students graduate from college, federal policies deny them authorization to work in this country. In addition, the residency status granted to students exists solely for tuition and attendance purposes. Because immigration policies are determined at the federal level, the granting of residency to students has no impact on their lives outside of the classroom or off of the college campuses. If an undocumented student manages to graduate from college, there are no formal or legal occupational opportunities available to them. Fundamental policies impacting immigration procedures are determined at the federal level. Changing the policies regarding citizenship status for these students requires federal legislation. Furthermore, federal changes must also be made to provide undocumented students with access to student financial aid (Puente, 2001).

Now is an optimal time to examine the issue of undocumented students' access to higher education. As the 2004 presidential race becomes increasingly contentious, Republicans and Democrats alike are fighting to win the coveted

Latino vote (Bumiller, 2004; Anderson 2004). The Latino vote is especially important because it is a rapidly growing part of the electorate and it is a population typically concerned with immigration issues (Shesgreen, 2003). A recent example is the Bush administration's proposed guest-worker program to protect the rights and wages of immigrants working in the United States (Mexican American Legal Defense and Education Fund [MALDEF], 2004). A window of opportunity has been opened (Kingdon, 1995), making it a promising time for the introduction of immigration policy initiatives. Additionally, mobilization efforts and legislative advances in some states indicate that there is some degree of public support for undocumented students. In the Freedom Rides during 2003, advocates for immigrants' rights traveled throughout the nation to push for immigrant-friendly legislation and reform. These events offer a clear example of the massive mobilization efforts taking place nationwide in support of immigrant rights (Kim, 2003).

Federal legislation similar to the DREAM Act would meet the needs of undocumented students and allow society to benefit from their potential contributions. A federal option brings national legitimacy, legality, and an enduring impact. In addition, there are three other significant benefits of marshalling federal legislation to help undocumented students in their pursuit of a college education. First, federal legislation would continue the precedent set by the Supreme Court decision on public education in *Plyer v. Doe* (457 U.S. 2002, 1982). The 1982 decision requires that public schools educate all children, regardless of their immigration status (Weissbrodt, 1998). *Plyer v. Doe* states that undocumented children should not be denied an education because of decisions made by their parents. Furthermore, the Court recognized that undocumented youth would likely remain in the United States for the duration of their lives; denying them the right to an education could have severe consequences for their future well-being (Weissbrodt, 1998). The same principles articulated in the Court's decision can be used today to support the case of undocumented students wishing to pursue a college education and become American citizens; the benefits of such federal reform would far outweigh all potential costs to society.

Second, federal legislation would benefit society in a number of ways, including a reduction in costs to the criminal justice system, a decline in the use of public benefits, and a decrease in school dropout rates (National Immigration Law Center, 2003*a*). At present, there is really no compelling incentive for undocumented students to work hard in school or become productive participants in civic institutions. As long as they remain illegal, their future is uncertain. In some instances, this uncertainty can lead undocumented

youth to choose a less-than-desirable path. As Carola and Marcelo Suárez-Orozco (2002) report, "If large numbers of immigrant children are not educated and graduate or are pushed out of schools without the required tools to make a living, it should not be surprising if crime and delinquency become serious issues as these children enter adolescence and adulthood (p. 49)."

Many undocumented youth grow up in urban communities plagued by violence, isolation, poor schools, and limited economic opportunities. As a result, many of these youth are enticed by the power available to them through involvement with gangs or illicit activities (Suárez-Orozco and Suárez-Orozco, 2002). Furthermore, undocumented students, particularly Latino students, drop out of high school at high rates (Breslin, 2002; Axtman, 2002). It is estimated that only 40 percent of foreign born, non-U.S. citizen children graduate from high school (LULAC, 2002). Federal changes would benefit society as a whole by contributing to the cultivation of productive citizens and encouraging the pursuit of a positive direction in life, as there would be tangible future options available to undocumented children if they stay in and finish school.

Federal legislation would also have broader affects on families. Suárez-Orozco and Suárez-Orozco (2002) assert that the legal status is crucial for immigrants in shaping their future life success and experiences. Undocumented or illegal citizenship status can have a negative and powerful impact on families (Portes and Rumbaut, 2001). Often, undocumented parents work hard to provide for their children. However, a family's commitment and hard work are not enough to ensure that undocumented youth will be able to attend college. Granting legal citizenship status to undocumented families would enable them to take advantage of services and resources, including financial aid (Portes and Rumbaut, 2001).

Finally, federal legislation like the DREAM Act would provide increased tax revenue to the United States (LULAC, 2002). These students are likely to remain in the United States and to find employment here. By providing them with access to college and citizenship, the federal government enables them to secure higher-paying jobs and to thereby contribute greater tax revenue. It is estimated that over 64 percent of undocumented students in Illinois would be qualified to enter college (Mehta and Ali, 2003). Such an influx of qualified students would result eventually in higher numbers of college-degreed workers, creating a larger pool of high-wage workers and significant increases in tax revenue. As George Borjas (1990) asserts, it is in the best interest of the United States to help immigrants assimilate economically by encouraging them to acquire the skills necessary to move ahead in society. These undocumented students are ideal recipients of educational and societal resources

because they are in a position to immediately benefit and succeed. Furthermore, these students cannot be ignored by society in the hope that they will leave the country or simply be absorbed by sectors of the economy that typically employ undocumented workers. Providing undocumented students with opportunities to realize their full potential benefits society socially and financially.

OPPOSITION TO LEGISLATIVE CHANGES

Some oppose any legislative changes easing policies towards undocumented students, asserting that granting undocumented students the right to attend college, obtain financial aid, and apply for citizenship sends the wrong message to immigrants and society as whole (An education in citizenship, 2003). Furthermore, opponents speak of undocumented immigrants as criminals, and contend that such changes would unfairly reward those who reside illegally in this country (Byrne, 2003). They allege that these students are no more entitled to amnesty than any of the other groups of undocumented immigrants who reside in the U.S. Opponents also argue that changing the laws would encourage more illegal immigration to the United States (Jervis, 2003*a*; Graham, 2002). In fact, the debate has grown very heated, with some opponents taking a drastic stance. For example, when the *Denver Post* reported the story of Jesus Apodaca, an undocumented student hoping to attend college, Congressman Tom Tancredo from Colorado began a campaign to have Apodaca and his family deported (Graham, 2002).

Some assert that federal legislation supporting undocumented students would take substantial federal money and financial aid away from deserving U.S. citizens (Jervis, 2003*a*). Others criticize the means by which advocates for undocumented students formulate their arguments, contending that those in favor of loosening restrictions for undocumented students base their positions entirely on subjective, emotional arguments, rather than realistic, objective, practical assertions (Wycliff, 2002). Personal experiences, such as those of Taina Unzueta and Miguel Parra (Puente, 2001), are very effective in conveying the human side of the issues, and there are thousands more stories like those of Taina and Miguel. While the personal stories of undocumented students may be powerful in mobilizing support for policy changes, this work has also sought to articulate the clear, tangible, objective benefits to enacting federal legislation that allows undocumented students to attend college, receive financial aid, and obtain citizenship. Furthermore, while federal policy changes would clearly reward deserving students, they also make practical sense on a national level.

CONCLUSION: BENEFITS OUTWEIGH THE COSTS

In spite of the fact that economics and immigration status exclude many of these students from college and productive citizenship, these limitations will not dissuade them from remaining in the United States. For many undocumented students, this country is the only home they have ever known. Because the United States benefits from the labor and taxes of undocumented immigrant families and participates in the global economy, it has a responsibility to provide a complete education to these students and their families. Opponents of federal action would simply ignore the fact that these students exist, all the while permitting undocumented workers to fill an important niche in the labor force of this country.

It makes sense to invest in these students now. By failing to do so, the nation will continue to incur the costs of the failure that these youth will encounter later. While these proposed changes may encourage more illegal immigration or reduce the financial aid available to all students, the situation of undocumented students cannot be ignored. They offer society a vast and untapped resource with infinite potential. Historically, immigration laws and policies have rarely seemed ideal at the time they were enacted. To some, this is also the case with current proposals affecting undocumented students. For this reason, any immigration issue or policy should be subjected to a cost-benefit analysis that simultaneously recognizes the history of this nation's immigration laws while looking towards the future. It is clear that there are practical and social benefits to federal policy changes that would allow undocumented students to attend college, obtain financial aid, and apply for citizenship. The DREAM Act offers an excellent example of the changes needed. Undocumented students deserve full access to college, financial aid programs, and recognition as American citizens. ■

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ABOUT THE AUTHOR

SUZANNE ROTH is a second-year student in the extended evening master's program at the School of Social Service Administration. She is a McCormick Tribune Fellow with a concentration is social administration. Suzanne graduated from the University of Michigan with a B.A. in sociology in 1998.

Nonprofit to For-Profit Hospital Conversions: Policy Implications and Alternatives

By Beth A. Tapper

The changing health-care market has resulted in shifts in the ownership status of hospitals in the United States. Many nonprofit hospitals are being sold to the for-profit sector and foregoing their philanthropic roots for greater access to capital. Consequently, communities are often left without adequate and accessible care for the indigent and charity care has diminished in many circumstances. Concerns over these changes have heightened public policy concerns over the quality of care and loss of community benefit. This article will discuss policy alternatives to these problems and offer viable solutions to many of the challenging outcomes of hospital conversions.

Changes in hospital ownership have provoked concern in the health policy arena, as many nonprofit hospitals have responded to market pressures by giving up their tax-exempt status and selling their assets to for-profit corporations. Consequently, as the pace of these changes has accelerated in recent years, conversion among hospitals from nonprofit to for-profit status has become a focus of national debate. These conversions represent the largest potential redistribution of charitable assets in the nation's history (Shactman and Fishman, 1996). Critical questions for policy makers have emerged: what effect will such changes have on the public benefit, and how can charity care continue to be delivered? Concerns about the viability of the nonprofit hospital and its philanthropic history in the health-care sector have prompted policy makers to evaluate the implications of conversion for the hospital industry, patients, and communities.

A fundamental concern is whether conversion of ownership from nonprofit to for-profit makes a difference in delivery of health care. It is unclear whether conversions will result in a loss of community benefit, but conversions may pose the risk for a drop in charity care, placing both uninsured and

underinsured individuals at a greater disadvantage. While some research comparing nonprofit and for-profit hospitals shows that for-profit hospitals inflate prices, raise expenditures, and neglect social obligations, policies can be enacted to protect patients and continue charitable care (Woolhandler and Himmelstein, 1999). Such policies should reflect current health policy goals that preserve valued functions and resources in the context of a competitive health-care marketplace. This article will discuss policy alternatives to this problem and offer viable solutions to many of the challenging outcomes that it creates. Further, this study will discuss and evaluate three policy alternatives: organized regulation and accountability, public participation in governance, and protection of charitable assets through the development of new foundations.

BACKGROUND

The majority of hospital conversions have occurred over the past two decades. Beginning first in the early 1980s and then resurging again in the mid-1990s, there have been increases in acquisitions by for-profit companies (Collins, Gray, and Hadley, 2001). Nonprofit hospitals often view selling to a for-profit company as the best alternative to ensure survival in an increasingly competitive marketplace. Hospitals are selling their assets to gain a number of perceived advantages, including access to capital markets, relief of debt burden, increased efficiency, and greater purchasing power. A hospital may also be motivated to convert in order to avoid closure, to continue the hospital's mission, to preserve or expand market share, or to reduce regulatory constraints (Cutler, 2000). Financial rewards inherent in for-profit ownership may provide incentives for hospitals to contain costs and respond effectively to patients' needs. Conversely, the opportunity to earn profits may lead hospitals to cut corners, take advantage of patients, and adopt a profit-maximizing strategy. How will communities fare with for-profit hospitals? Who will ensure continued access to care for the uninsured and other vulnerable patient populations? Will nonprofit organizations receive a fair price for their hospitals? Is there a process to ensure that the charitable assets will continue to serve the public interest? These questions need to be addressed by policy makers when evaluating the implications of conversions.

COMMUNITY BENEFITS AND THE VALUE OF NONPROFIT HOSPITALS

The retention and safeguarding of nonprofit hospitals is important for many reasons. Three rationales support special status for nonprofits: charity care, community benefits, and consumer protection (Marsteller, Bovbjerg, and

Nichols, 1998). In exchange for favorable tax exemptions, nonprofit hospitals are required by law to satisfy certain social obligations, including the delivery of charity care and other services to the indigent. There are also numerous community benefits to having a nonprofit hospital serve a community, provide charitable care, and steer charitable giving. Conversely, profit-driven concerns for efficiency are motivations among for-profit hospitals. For-profit providers answer to shareholders and focus on the bottom line. It is also asserted that for-profits provide less care for the uninsured, fewer unprofitable services, less medical teaching and research, and less accountability to the community (Claxton et al., 1997). Nonprofit ownership may therefore enhance the potential for community benefit, while for-profit ownership may preclude quality patient care and equal access.

Defining and valuing community benefits is important, because nonprofit hospital conversions may reduce these benefits. First, measurements of community benefits include a hospital's provision of charity or uncompensated care (Claxton et al., 1997). Nonprofit hospitals view the provision of uncompensated care to those who are unable to pay as a major part of their mission. Second, nonprofit hospitals spend a considerable amount of time and money on medical research and education. This investment provides community benefit. Third, non-reimbursable or unprofitable services, such as 24-hour emergency room trauma care and burn centers, are often provided at a loss to the hospital. Fourth, community representation on the board is a community benefit because hospitals may be more receptive and responsive to local health care needs, and this may be an indicator of the hospital's interest in serving the needs of the community (Young and Desai, 1999). Lastly, community benefits may include broader views, such as minimizing the burdens of cost to families and contracting with essential community providers (Gray, 1997).

Opponents of conversions have pointed to evidence that, compared to nonprofit hospitals, for-profits provide fewer services benefiting the broader community (Gray, 1997; Claxton, et al., 1997). Hospital conversions usually involve the sale of a nonprofit institution's assets to a national for-profit chain that is often headquartered elsewhere. Nonprofit hospital directors generally live in the hospital service area, interact with local residents, and have direct interests in the community's health-care needs. When a nonprofit hospital is sold to a for-profit corporation, these local sources of influence and control are reduced. For-profit hospitals may be less likely to undertake unprofitable programs that improve health, because decision makers have fewer ties to the community (Horwitz, 2002). Conversions of nonprofits to national for-profit chains may therefore cause hospitals to lose their local identities and neglect

community benefit.

Conversions may establish a divide between the hospital's mission and the needs of the community it serves; unprofitable community services and charitable care are lost, and communities are left with fewer of the valued benefits. Consequently, the pressure to make a profit can render the for-profit hospital unreceptive to the needs of the host community. Proponents of conversion argue that any community losses from conversion are offset by financially strengthened institutions, an increase in community tax revenues, and the redirection of nonprofit assets to other charitable purposes. Conversion advocates argue that with the inclusion of increased tax revenues, for-profit hospitals provide greater benefit than their nonprofit predecessors (Marschke, 1997). Proponents also maintain that in some oversaturated markets where failing hospitals might be of questionable value to communities, for-profit owners of multiple hospitals in the same markets claim to benefit the community and reduce redundancy by shutting down institutions that nonprofit boards were unwilling to close (Gray, 1997).

RESEARCH ON CONVERSIONS: ARE THEY REDUCING QUALITY AND SACRIFICING CHARITY CARE?

A vast amount of research examining the conversion process and its implications reveals conflicting arguments between opponents and proponents of conversions. Some national data suggest only minor differences between nonprofits and for-profits in the provision of charitable care, while others suggest that differences are more readily apparent when making comparisons within specific states. Some research has shown that conversions can lead to lower quality health-care delivery coupled with greater costs to both consumers and insurance companies.

A large study by Sara Collins, Bradford Gray, and Jack Hadley (2001) examines conversions and their long-term impact on community benefit activities and financial performance. In Illinois, for example, Michael Reese Hospital was purchased by Humana in 1991 as part of deal to purchase the hospital-owned HMO. Collins and associates (2001) assert that community benefit appeared to decline post-conversion. At the time, it was a 600-bed prominent teaching hospital on Chicago's near south side. Collins and colleagues (2001) find that after conversion, it shrunk to 150 beds, with little teaching or research. Moreover, the hospital underwent three ownership changes and several changes in administration under each of its owners. The teaching and research activities went into a decline after Humana purchased

the hospital in 1991. Neither Humana, nor it successor, Columbia/HCA, had substantial experience running a teaching hospital and their management deemphasized that aspect of Michael Reese's activities (Collins et al., 2001). As part of its teaching and service mission, the hospital had also operated several specialty outpatient care clinics that served the local community. The new management consolidated and closed some of the clinics.

A review of 20 available studies of community benefits finds that nonprofits provide significantly more community benefits than do for-profits, particularly when comparisons are made among hospitals within a given state (Claxton et al., 1997). It also finds a wide variation among nonprofit hospitals, with public and large teaching hospitals providing a disproportionately larger share of community benefits (Claxton et al., 1997).

Other literature reveals that problems with conversions can often lead to negative and unforeseen outcomes. A study by Gary Young and Kamal Desai (1999) examines the impact on communities of conversions of nonprofit hospitals to for-profit status. They conclude that after conversions, hospitals shift the composition of their governing boards, including fewer community representatives and more hospital senior management (Young and Desai, 1999). Some research shows that hospital conversion from nonprofit to for-profit status is more costly per patient, and is associated with a decrease in the ratio of staff to patients (Mark, 1999). A study by Steffie Woolhandler and David Himmelstein (1999) in the *New England Journal of Medicine* concludes that for-profit hospitals are more expensive than nonprofit facilities. For-profit hospitals cost Medicare an additional $732 per enrollee, or an extra $5.2 billion annually. They also assert that prior research confirms that for-profit hospitals are 3 to 11 percent more expensive than nonprofit counterparts. So too, for-profits spend more on overhead and administration costs while hiring fewer nurses, providing less charity care, and allowing patients fewer days of inpatient care (Woolhandler and Himmelstein, 1999). However, these findings do not indicate that the for-profits are less efficient. Benefits may accrue from the for-profit emphasis on a streamlined workforce and shorter inpatient stays.

Another study by Gabriel Picone, Shin-Yi Chou, and Frank Sloan (2002) examines mortality rates among nonprofit hospitals and those that converted to for-profit status. They find that among hospitals that converted from nonprofit to for-profit status, there was a statistically significant increase in mortality rate at 1 year following conversion. These effects persisted for first 2 years following conversion, but disappeared after 3 or more years. There was a similar pattern for mortality at 30 days and at 6 months after hospital admission, but effects were not statistically significant at conventional levels (Picone,

Chou, and Sloan, 2002). As a result of many of these studies, a growing body of research shows that patients in for-profit hospitals receive a different level of care than those in nonprofit settings. This underscores the need for greater oversight and regulation. These findings, however, could be explained by the adjustments, such as acclimating to new management and staff, that take place in the conversion process. Further, long-term studies are needed to ascertain whether or not these differences will be important in the long run.

CURRENT POLICY PROBLEMS AND CONSEQUENCES

Although the benefits of efficiency and competition may lead to a more streamlined health-care system, the ramifications of allowing hospital conversion without adequate policies for regulation are cause for great concern. Whether nonprofit and public hospitals should be allowed to convert to for-profit status continues to be an issue of contention. If so, what are the parameters of, and restrictions on such conversions? Since the primary motivation of the for-profit is concerned more with the profit margin, policy needs to be altered and more strictly enforced. Policy should outline regulatory standards that force for-profit hospitals to adhere to similar procedures of accountability and practice of nonprofits. Standards and hospital practice should include recognition of social obligations to vulnerable populations and community involvement. Goals should consider including measures of community benefit, including uncompensated care, provision of unprofitable services, price discounts, and community representation on governing boards.

Regulation and oversight has also been a problem in hospital conversions. To date, there is no comprehensive federal oversight of hospital conversions. State laws generally do not specify a supervision process, and many state legislatures have not fully considered the public policy issues related to the conversion activity. In addition, many states lack the resources necessary to sufficiently deal with the complexity of the conversion transactions. A study by Jill Horwitz (2002) explores the current trends of hospital conversions from nonprofit to for-profit status and how the well the public interest is protected. Many times, converted assets, meant for charitable purposes, are not accurately valued and are transferred to for-profit buyers or executives of the nonprofit sellers (Horwitz, 2002). One failure of the current system is that assets have been sold for less than their fair market value (Shactman and Fishman, 1996).

While the state's attorney general is typically charged with overseeing these transactions, he or she may suffer from a lack of knowledge on the subject, and may not always receive sufficient notice of conversions (Horwitz,

2002). In Illinois, for example, the attorney general is not given notice of a conversion; it is only after the conversion occurs that any possible oversight may be conducted (Horwitz, 2002). Many nonprofit hospital sales have been conducted in private, often with only a small cadre of the board and management privy to the transaction terms. The community is often unaware of the pending sale, its price, structure, or terms, and is often denied opportunity to provide input. Such exclusion contradicts hospitals' stated commitment to public benefit, and leaves communities vulnerable.

Given the inconsistencies in provisions and regulations, it is relevant to ask whether and how proposed conversions affect health-care delivery. Since health care is not only important to individual welfare, but also serves to improve the public good, a key component of the analysis of a proposed conversion is the extent to which the resulting for-profit entity will alter or abandon the predecessor's charitable nonprofit mission. If the health-care industry currently seeks to lessen the disparity in access to health care amongst racial and socioeconomic groups and to decrease incidence of disease, then the industry should ascertain how hospital conversions are either helping or hindering these objectives. Will race, class, and access to care continue to stretch and challenge the legitimacy of private, for-profit ownership? Are for-profit objectives congruent with those of nonprofit hospitals? In light of these concerns, greater public oversight is needed to scrutinize the valuation of conversion targets, to develop strategies that stabilize access to care, and to maintain community benefit. In order to develop standards for the disposition of community assets, it is important to gain a better understanding of the impact of conversion on the financial stability of hospitals, on the range of services that they provide, and on access to care in the community.

THREE POLICY ALTERNATIVES

Regulation

Effective regulation of hospital conversions is needed to protect the public interest in two important areas: heath and money (Horwitz, 2002). Proposed alternatives to the current systems of inadequate oversight include the creation of stronger regulations, as well as state and federal guidelines that provide a framework for conversions. To ensure that community benefits are fulfilled, regulation should require minimum standards of care. Conversions affect not only health-care organizations, but also communities' access to, and use of charitable assets. Yet, most states have neither enacted specific legislation nor

instituted any specific process to oversee health-industry conversions. States differ greatly in the level of stringency that their charitable trust laws apply to hospital conversions. Some states have enacted legislation or used regulatory powers to negotiate with for-profit successors to ensure continuation of specific levels of charity care and health services after conversion. In some states, public officials (mainly attorneys general and insurance commissioners) have aggressively pursued individual interpretations of charitable trust and other laws to oversee conversions and promote public involvement. In other states, however, officials have been more reactive.

Therefore, to address these inconsistencies, states should establish a formal oversight process that is backed by federal policies, and that process should be enacted legislatively. Federal guidelines for states should include five specific measures. First, new federal guidelines should require detailed descriptions of how charitable assets and purpose are being preserved by for-profit successors. Without public consideration of the amount of money set aside and for designated purposes, conversions threaten to eliminate significant community resources and services. Second, federal guidelines should permit ownership conversions to occur only if the social benefits of for-profit ownership exceed the social costs (Robinson, 2000). Conversion, then, should not be based solely on the needs of the hospital owners. Owners must consider the implications of the event for patients and the needs of the community. Third, federal guidelines should require states to monitor local market conditions through community-benefits assessments (Marsteller et al., 1998). This will allow states to assess what is gained and lost from conversion. Fourth, federal mandates should require states to designate an official, such as an attorney general, who will be notified of a possible conversion. If conversion occurs, attorneys general must demonstrate formal oversight and ensure that public benefit will not be compromised in the process. Finally, the government should regulate the conversion rate of hospitals so that there is a proper balance of for-profit and nonprofit hospitals. Competition and balance between nonprofit and for-profit hospitals may result in lower costs and improved market performance.

The health policy issues that arise in conversions might be best addressed by a team of state experts. Such teams might include health officials, policy makers, and hospital administrators. This approach has not been widely adopted to date, but some state regulators are looking increasingly to others in government for assistance (Shriber, 1997). Policies should establish an efficient and accountable process through which possible conversions can be evaluated and actual conversions managed. Since many for-profit hospitals are owned by

larger national entities that may own several hospitals in numerous states, it is only reasonable to create national guidelines on how hospitals can manage newly acquired assets. By overseeing the appropriate disposition of nonprofit assets in individual conversions, tighter control will be gained over how money is spent and resources are allocated.

To ensure that state regulators appropriately and systematically address the policy issues raised by conversions, consumers and other organizations, along with regulators and legislators in some states, are calling on states to enact legislation that clarifies regulatory authority and responsibility in the conversion process (Claxton et al., 1997). A few states have passed such legislation. These legislative initiatives address a wide array of procedural and substantive issues, including the basis for, and locus of regulatory authority; the kinds of transactions subject to that authority; the formulation of a regulatory process for preconversion review; the requirement for independent and accurate valuation of assets; the definition of the proper role of citizens and community groups; the initial governance and mission of charitable foundations; and the evaluation of the impact of the transaction on the health-care system (Gray, 1997). Regulations that are too stringent, however, can be used to protect the status quo. Such regulations may also stifle the competition that could result in lower prices and, hence, increased access to care. In legislating and implementing a regulatory process, states must find the appropriate balance for their communities.

Public Participation

A second policy alternative is to incorporate public participation in the conversion process. This alternative recognizes that community health policy issues should be decided by those who are most affected. Despite the potential impact of conversions on a community's health-care services and charitable assets, there is typically no process for the community to express views, raise objections, and intervene in conversion decisions (Claxton et al., 1997). Potential ways for the public to participate in conversions might include public hearings, formal input into a regulatory process, creation of legal standing to challenge transactions, and input into the disposition of charitable assets (Claxton et al., 1997). This job should be delegated to public servants with substantive health-care and policy training (Horwitz, 2002). It would also be advantageous if policies required some community representation on governing boards. In deciding how to facilitate public input, states must balance the need to prevent private abuses and the loss of charitable assets with the

need to provide an efficient, unobtrusive regulatory process. Although these hospitals may be private and ownership is typically not local, they can adopt individualized identities and ties with communities. With public participation, there is greater likelihood that community needs will not be overlooked. This will encourage continuity of service in the conversion and may foster trust in the community, instead of skepticism.

New Charitable Foundations

Finally, policy alternatives that ensure access to charity care can be achieved by creating foundations that fund the charitable care formerly provided by the nonprofit. A good way to ensure this is to encourage the creation of new, joint-venture foundations. When a charitable organization is dissolved, issues arise regarding the creation, initial governance, independence, and mission of the new charitable foundations that are being established to carry out the hospital's original charitable purpose. Here, a joint venture between the nonprofit hospital and the for-profit successor would result in a partnership to manage the assets transferred by the nonprofit in conversion. This joint venture would exist as a nonprofit foundation. The nonprofit hospital would contribute its charitable assets in exchange for cash and ownership interest in the new venture. The for-profit entity would contribute capital to the joint venture, receiving an ownership interest of 80 percent (Claxton et al., 1997). Consequently, the foundation would become the holder of the nonprofit hospital's 20 percent interest in the new venture. In 1996, for example, there were 60 such foundations with over $5 billion in assets (Claxton et al., 1997). Such foundations would ensure that the public good is still maintained in some capacity.

When forming joint ventures, states should require that all proceeds from a conversion transaction between a nonprofit hospital and a for-profit entity be placed in a foundation independent of the parties involved in the transaction. This transaction and the transfer of proceeds to an independent foundation should be overseen by agencies that govern nonprofits. This would ensure that the foundation is responsibly using proceeds of the sale and maintaining a strong level of community benefit. In doing so, overseers can prohibit officers and shareholders involved in the transaction from serving on the foundation. Regulators would also require the foundation to dispose of proceeds arising during conversion from the sale of a community benefit asset. Disposal of the assets should be completed in a manner consistent with the community benefit purposes of the asset.

EVALUATION OF POLICY ALTERNATIVES

Regulation

As previously noted, conversions are most often regulated by attorneys general, but there are many barriers to effective oversight. Depending on the organization of a state attorney general's office, one of several divisions may oversee conversions. These divisions include: charities, consumer protection, corporations, health care, taxation, and trade regulation (Horwitz, 2002). In an extensive review of state conversions, Horwitz (2002) concludes that although many states are using attorneys general to monitor conversions, the process is filled with inconsistencies and problems. By obtaining data from 32 states and their attorneys general, Horwitz (2002) finds that current and developing oversight methods do not adequately protect the interests of the public. Horwitz also finds that the great majority had primary authority to oversee hospital conversions (Horwitz, 2002). However, in 7 of the 32 states studied, state attorneys general did not oversee conversions. Horwitz notes that in West Virginia and Louisiana, for example, attorneys general are barred from reviewing conversions because the states will not agree to be a party in an action against a for-profit buyer (Horwitz, 2002). Therefore, despite a statutory method that appears to encourage oversight, the attorneys general have not reviewed any conversions. The striking similarity of responses across states in Horwitz's research, however, suggests that the results can be used to identify emerging laws and policies, anticipate trends, and draw conclusions about these approaches (Horwitz, 2002).

Another research study by David Shactman and Andrea Fishman (1996) examines how many states have passed legislation specific to conversion. The findings reveal that most states have not initiated legislative or regulatory action specific to hospital conversions. Among the states that have, the regulation varies considerably (Shactman and Fishman, 1996). Moreover, they find that some states have negotiated with successor entities for provision of minimum levels of charity care and other community benefits. A few states, such as California and Nebraska, have enacted legislation that specifically mandates consideration of future benefits to be provided to the community after a conversion (Shactman and Fishman, 1996). These, however, are the only two states with statutes that require notification of conversion. Legislation passed in many other states sets standards for conversions. The clear propensity for discontinuity in the conversion process is demonstrated by the reported variations in oversight by attorneys general (Horwitz, 2002) and the policy differences

across states (Shactman and Fishman, 1996).

Charitable Foundations

As a result of conversion trends, assets of new charitable foundations have been on the rise (Williams and Brelvi, 2000). Foundations around the country fund a variety of health activities in their communities, health and wellness programs, women's health services, and substance abuse treatment programs (Williams and Breivi, 2000). In Chicago, for example, many conversions have resulted in the creation of charitable trusts. The Michael Reese Health Trust is the largest foundation in the Chicago area dedicated exclusively to funding health care, particularly health care that meets the needs of vulnerable and underserved Chicagoans. The trust is now valued at over $100 million (Collins et al., 2001). Conversions involving joint ventures, though, sometimes are not considered in existing regulatory procedures. For example, conversions that are structured as joint ventures often do not generate government oversight (Horwitz, 2002). In the Michael Reese case, for example, Humana negotiated a 4-year, front-loaded, $54 million subsidy to be paid as part of the sale by the Michael Reese Health Trust (Collins et al., 2001). If proper oversight was in place, the trust would not have used any of its money to fund the hospital. Despite the establishment of newly formed ventures, room for improvement can still be achieved through regulation.

MOVING TOWARDS A BETTER POLICY ALTERNATIVE

Ownership status alone is not likely to determine a hospital's commitment to the community or to safe, quality care. Without clear lines of accountability to the community and clear standards for community services and quality care, it cannot be assumed that merely maintaining a hospital's nonprofit status will ensure preservation of the traditional mission. Among the three policy alternatives presented, no one alternative is more important than the others. Rather, it is most important that policies enable more comprehensive regulation, ensuring the fairness of conversion across all states. The past few years, however, have shown a marked increase in regulation and in standardizing procedures. Most states attorneys general are now involved in some supervision of conversions, even if that oversight is frequently inconsistent. The development of new foundations also serves as a viable alternative to banning conversions. These foundations can then fund the charitable care formerly provided by the nonprofit hospital. Foundations may also provide added benefit to communi-

ties. Due to overwhelming structural problems and red tape, such foundations may be managed more efficiently and better able to target vulnerable populations that the nonprofit hospital.

CONCLUSION

Nonprofit hospitals may enhance the potential for community benefits and protect the assurance of equal and accessible care. Because conversions represent sources of federal and state tax revenues and capital can be made on these transactions, it is difficult to enact legislation that will curb the sale of these hospitals. It is evident, though, that if nonprofit hospitals continue to be converted without adequate public oversight into private, competitive, for-profit entities, vulnerable populations will see additional declines in adequate, accessible health services. With an influx of hospitals converting to the for-profit sector, these issues need to be addressed through policy changes at the state and federal levels. Policy to address this problem should incorporate stimuli from the public hospital sector, government regulatory agencies, and the community at large. Such stimuli should be based on stronger guidelines for provision of charity care. Efforts should also address the needs of vulnerable populations while ensuring comprehensive state and local monitoring of performance. Further, federal and state policies should require strong public oversight of conversions and mandate direct community control in determining a hospital's community benefits. These practices should be implemented across all states. Consequently, no one policy alternative will be sufficient. The problem requires a collection of approaches and solutions. New policies must be adopted and enforced. If this occurs, conversions may someday be viewed more favorably by those who so outwardly criticize them now. ■

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ABOUT THE AUTHOR

BETH A. TAPPER is a second-year social administration student at the School of Social Service Administration and is in the Graduate Program for Health Administration and Policy. She is a graduate of the University of Wisconsin-Madison with a bachelor's degree in sociology. She is interested in health policy research and health care consulting. She is an intern at the University of Chicago Hospitals in the General Internal Medicine Outcomes Research Department.

Aging in a Diverse Society: The Role of Cultural Competency in Mental Health Care for Older Adults

By Elizabeth Bowen

The elderly population in the United States is becoming increasingly diverse, and this trend underscores the need for culturally competent health care services for older adults. As attitudes about mental illness are strongly shaped by cultural values, there is an acute need for cultural sensitivity in the mental health care sector. This article explores the meaning of cultural competency in the context of mental health service provision, and offers a brief overview of service models that emphasize cultural sensitivity. The unique role that social workers can play in enhancing cultural competency in mental health care for older adults is emphasized.

With regard to health status, socioeconomic status, race, ethnicity, and culture, America's elderly are a diverse group. Of all these factors, culture is among the most critical to consider in providing effective mental health care for elderly clients. In spite of this, the mental health care system has historically been inadequately responsive to the varying needs of culturally diverse elderly clientele (Aranda, 1990). Given the growing diversity of the elderly population, and the impact that clients' cultural contexts have on the diagnosis and treatment of mental illness, there is currently a critical need for cultural understanding and sensitivity in the mental health care system. The social work profession can play a unique role in ensuring cultural competency in mental health care, at both the micro and macro practice levels.

In order to demonstrate the need for cultural competency in mental health care, this article will explore theoretical explanations of the role that culture plays in conceptualizing both mental health and aging. In addition, the article will seek to define cultural competency, to demonstrate the need for

culturally competent mental health care for the elderly, and to evaluate the policy implications of these objectives. The role of the social work profession in providing appropriate, sensitive care will be explored, and this article will suggest exemplary service designs that can provide truly culturally competent mental health care for older Americans.

CULTURE AND ITS RELEVANCE TO MENTAL HEALTH CARE FOR THE ELDERLY

In considering the treatment of mental health conditions of the elderly, culture plays two roles. First, culture affects the ways that mental illnesses are viewed, diagnosed, expressed, and treated in any society. In addition, culture shapes perceptions and ideas about aging. On a fundamental level, David Takeuchi and Katherine Kim (2000) postulate that mental illnesses are defined by arbitrary boundaries. These boundaries depend on how a culture labels different behaviors as deviant or sick. Within a society, cultural biases and prejudices toward certain groups may affect who is judged to have a mental illness. For example, since the U.S. Census Bureau began collecting data on patterns of mental health treatment in 1930, nonwhites have shown higher rates of insanity than whites in every census report (Vega and Rumbaut, 1991). While the actual prevalence of mental disorders may be affected by such factors as the overrepresentation of racial and cultural minorities in the United States among lower socioeconomic classes, the role of culture (and cultural biases) cannot be dismissed in defining and diagnosing mental illnesses.[1]

Culture also influences the ways that symptoms of mental disorders are expressed. In many cultures, including those of Mexico and China, there is a tendency to somaticize symptoms of mental illness, manifesting psychological discomfort in physical complaints (Vega et al., 1999). Takeuchi and Kim (2000) offer the example of both Chinese mental health professionals and their clients preferring a diagnosis of neurasthenia rather than depression, with its focus on emotional distress. Neurasthenia is a term used to describe physical discomfort and fatigue as a response to stressful events.

Once the symptoms of mental health disorders are expressed and identified, culture affects the avenues through which individuals seek treatment. The methods of intervention for mental health problems are varied. Some examples include turning to one's extended kin network for social support, using formal psychotherapy and drug treatment, and obtaining the services of a shaman or indigenous healer. Culture is one of the primary factors determining the interventions to which a person may have access, and culture also influences preferences for different modes of treatment. In addition, stigmas associated

with mental illness vary from culture to culture, and their weight affects whether or not a person will seek any sort of treatment in the first place (Takeuchi and Kim, 2000).

In providing mental health care for culturally diverse elderly clients, professionals and service providers must be aware not only of the role that culture plays in conceptualizing mental health and mental disorders, but must also be knowledgeable concerning the wide-ranging effects of culture in shaping beliefs and values about aging. Simon Dein and Sarah Huline-Dickens (1997) propose that in every society, different rights, duties, expectations, and privileges are associated with reaching old age. These rights and privileges may be enforced both through formal laws and informal social sanctions. So too, old age is culturally defined, and varying definitions may take into account physical and social functioning, as well as chronological age.

Dein and Huline-Dickens (1997) also point out that there has been relatively little cross-cultural research examining which aspects of aging are universal (and thus unavoidable) and which aspects are culturally defined (and therefore not an inevitable part of the aging process). According to Dein and Huline-Dickens (1997), there is no empirical support for the notion that social disengagement among elderly people is an inescapable, universal phenomenon. Disengagement may be relatively widespread among elderly people in Western cultures and may be intensified by the Western emphasis on the connection between a person's social worth and productivity. However, this is not true in every society (Dein and Huline-Dickens, 1997). The Sherbro people of Sierra Leone, for example, interpret incoherent speech in old age as the elderly person's communications with revered ancestors and, thus, associate elderly status with wisdom and good fortune (Palmer, 1997).

In any assessment of the influence of culture on perceptions of aging, it is also important to consider the role of religion. Religious values strongly influence beliefs about death and the extent to which death is feared. Such beliefs often serve as a source of comfort for elderly people who are dealing with loss and grief (Dein and Huline-Dickens, 1997). In certain religious traditions, such as Taoism and Confucianism, being elderly is associated with wisdom, honor, and mastery (Palmer, 1997).

WHAT DOES IT MEAN TO BE CULTURALLY COMPETENT?

In the context of mental health care for elderly people, cultural competence refers to integrating an understanding and awareness of the client's culture into all aspects of service delivery, including assessment and diagnosis, treatment

interventions, and termination. This may involve the creation of programs designed specifically for elders of certain racial, ethnic, or religious backgrounds. Cultural competency can be practiced in agencies that serve a diverse body of clientele. Donna Yee (1997) defines cultural competency as the use of social work problem-solving techniques to respond to the elderly client's needs in the context of the client's culture and family. In its essence, this process should involve emphasizing the client's culturally based strengths while strategizing to overcome barriers that threaten to prevent minority elders from receiving effective treatment.

THE NEED FOR CULTURAL COMPETENCE IN THE AMERICAN HEALTHCARE SYSTEM

With sharp increases in both the number of elderly persons and the minority population, cultural competency in mental health care for older adults has never been more important. Census figures show that in 2002, 30 percent of Americans classified themselves as African American, Latino, Asian American, or Native American (U.S. Census Bureau American Community Survey Office, 2003). Richard Schaefer (2000) reports that this number is expected to rise to 47 percent by 2050. Focusing on the segment of the population that is over 65, Tobi Abramson, Laura Trejo, and Daniel Lai (2002) summarize a 1992 Census Bureau report predicting substantial increases in the number of elders of color. Among the elderly in some racial and ethnic groups, the rate of increase could be as much as 625 percent or as little as 150 percent.

Despite these remarkable demographic trends, the mental health care system has not kept pace in providing effective care for diverse elders. A recent report from the U.S. Surgeon General reveals that cultural minorities of all ages are significantly less likely than whites to receive adequate mental health care in the U.S. (McCarthy, 2001). This is due to a host of factors, including lack of health insurance, unavailability of treatment in minority communities, and the failures of therapists and treatment models to acknowledge the cultural context of mental health. When coupled with the potential barriers to treatment that elders experience regardless of racial and cultural identification, minority elders are truly in a position of "double jeopardy" (Dowd and Bengston, 1978, p. 427). Such barriers include strong stigmas associated with the presence and treatment of mental disorders.

A more detailed investigation is warranted of the barriers to treatment faced by elderly minorities. Jennifer Alvidrez (1999) studies minorities across the age spectrum and classifies barriers to treatment into two categories: instrumental and psychological. The term "instrumental barriers" refers to

resource factors that prevent people from seeking treatment, including lack of health insurance, money, time, or transportation (Alvidrez, 1999, p. 516). In 2001, Bernadette Proctor and Joseph Dalaker (2002) reported U.S. Census Bureau data showing that minorities live in poverty in numbers disproportionate to whites; this is especially true for Latinos and African Americans, over 20 percent of whom were living below the federal poverty line in 2001. This information is critical in understanding barriers to treatment, because the stresses associated with living in poverty may exacerbate the rates of such mental disorders as depression and anxiety. Both are already prevalent in the elderly population, complicating efforts to obtain treatment. A related factor is lack of health insurance. Takeuchi and Kim (2000) report that an estimated 44.3 million Americans do not have health insurance. This problem is particularly severe among immigrants and racial and ethnic minorities. About one-third of all Latinos, for example, are uninsured (Carrasquillo et al., 1999).

The second type of barrier identified by Alvidrez (1999), "psychological," refers to cultural factors that prevent people from seeking treatment even when services are financially accessible (p. 516). These factors include stigmas associated with mental illness, family and cultural beliefs about the causes and expressions of mental disorders, and exposure within a cultural context to different systems of mental health treatment. Elderly people across cultures are often unfamiliar with the range of mental health services available in their communities, and many attach a negative stigma to seeking treatment, believing that mental health problems should be addressed individually or within the family (Burstein, 1988). These trends may be especially pronounced in particular cultural communities. For example, African-American, Latino, and Native-American cultures traditionally emphasize family support and frequently advocate treating problems within the family, extended kin network, or immediate community. Nonetheless, mental health care providers must take care not to assume that all minority elderly prefer or will have access to adequate care within their family or community (Dein and Huline-Dickens, 1997).

Even if elderly minorities are able to overcome these instrumental and psychological barriers to seek treatment for mental health problems, they still face a system of care that historically has not responded effectively to their needs. For example, many of the standardized measures used to diagnose mental illnesses were developed with inadequate representation of both minorities and elderly persons in the research samples (Vega and Rumbaut, 1991). Dein and Huline-Dickens (1997) assert that measures of dementia may be especially susceptible to cultural biases, because these measures often do not

account for the elderly person's level of education, and conceptions of dementia differ significantly across cultures. Furthermore, many mental health agencies are not able to match elderly clients with therapists who share a knowledge of their cultural background and native language. For example, despite the fact that the population of Latino elders in Southern California numbers upward of 160,000, a 1987 survey in Los Angeles County revealed that programs for Spanish-speaking elders, staffed by bilingual therapists trained to work with older adults, were offered by only three of the 81 agencies in the county (Aranda, 1990).

SOCIAL WORK AND THE PROVISION OF CULTURALLY COMPETENT CARE

The role of social workers in providing culturally competent mental health care for a diverse elderly population is delineated by professional ethical standards and by a strengths-oriented philosophy in both micro and macro practice. To begin, cultural competence is an ethical guideline set forth by the National Association of Social Workers (NASW) as a standard for the entire profession. To this end, the NASW Code of Ethics states that social workers should demonstrate a working knowledge of their clients' cultures, and provide services in a manner that is sensitive to the cultural differences among people of diverse backgrounds and groups (NASW, 1999).

Beyond this, culturally competent practice with elderly adults provides an avenue for tapping into a client's full range of strengths and resources. For example, Gene Cohen (1993) argues that African Americans have generally developed a greater array of coping mechanisms by the time they enter into old age. This is perhaps due to a lifetime of dealing with prejudice and other threats to self-efficacy and self-esteem. A skilled social worker can tap into this wellspring of strengths to provide effective mental health treatment, helping African-American elders maximize their growth and functioning.

Cultural strengths may also be drawn from the ways that families from different cultures respond to the potential strain of caring for an elderly member. For example, Vicki Hines-Martin (1992) finds that African-American caregivers show less strain, on average, than whites in caring for chronically ill elderly relatives. So too African Americans are less likely to place elderly family members in nursing homes or other institutions. As social workers strive to provide competent mental health care for an increasingly diverse population of older adults, potential community resources, including extended kin networks and religious institutions, must be acknowledged and integrated into treatment plans.

SERVICE DESIGNS AND MODEL PROGRAMS

While the minority elderly population may be underserved as a whole, there are a number of culturally competent mental health care programs for older adults. These programs should serve as examples to other care providers in the field. To begin, the American Society on Aging (ASA) has developed a number of innovative programs addressing both the mental and physical healthcare needs of the multicultural elderly population. In 1996, ASA founded "Serving Elders of Color: A Training and Networking Initiative" (Jeung, 2004). Under this project, ASA works with other organizations, such as the American Association of Homes and Services for the Aged and the National Association for Home Care, that provide care for the elderly. Together, the coalition seeks to maximize cultural competency. The Serving Elders of Color project shows agencies how to conduct diversity needs assessments and provides diversity trainings to staff. The initiative also establishes a network and newsletter through which participants can share information and provide advice to one another.

Another initiative created by ASA, the California Multicultural Institute for Aging and Healthcare is designed specifically to meet the needs of elders of color and gay, lesbian, and bisexual elders throughout the state of California (American Society on Aging, 2002). The Institute works with agencies that provide health and mental healthcare services to the elderly, helping them to conduct research that evaluates baseline data on the services that each agency provides. This is achieved by setting goals for maximizing the cultural competency of care (for example, improving diversity on governing boards and increasing bilingual staff), by implementing trainings and additional service provision to meet these goals, and by evaluating the results.

In addition to the ASA, other service providers across the country are responding to the need for cultural competence. One exemplary program is Realizing Empowerment and Service Possibilities for Elders in Communities Together (RESPECT), based in Roxbury, MA (Yee, 1997). This project trains elders of color from historically underserved communities to work as cultural translators and peer advocates. These recruits help to identify other elders in the neighborhood with mental health care needs, and to inform them of available services. The peer advocates also accompany staff from mental health and elder care agencies on their home visits, facilitating communication while helping to bridge gaps of culture and age between the client and the service provider. According to Yee (1997), this helps clients feel more in control and less vulnerable. It may also help service providers and case managers feel more comfortable in bringing up sensitive issues that they might otherwise be

tempted to ignore.

Another example of culturally competent mental health care for the elderly can be found on the opposite coast, at the San Antonio Mental Health Center in Los Angeles County. This clinic primarily serves a low-income clientele, 10 percent of which is elderly, and the majority of which is Latino (Aranda, 1990). The San Antonio Mental Health Center is committed to cultural competence at all levels of service provision, from outreach to program design. To make the community more aware of the services that the center offers, the staff conducts outreach activities in places where elders of color are likely to congregate, such as predominately Latino churches, and provides informational materials, such as videos and pamphlets in Spanish, to educate the public on such mental health conditions as Alzheimer's disease.

When elderly Latino clients come in for treatment, the staff assesses the client's level of acculturation, as well as that of his or her family (acculturation levels may differ significantly within a family, as many Latino elders are immigrants). Treatment progresses with an integration of traditional values that are important to the elder, such as family reliance and interdependence. Staff at the center also explores with clients the cultural beliefs about aging. A yearly celebration of El Dia del Los Muertos, or Day of the Dead, is held at the agency. The event raises awareness of the values about death and aging that are conveyed by this Mexican tradition. The clinic also does group work with elderly clients and their families. Such work includes hosting the country's first Spanish-language Alzheimer's support group and offering peer counseling to clients with trained elderly Latino volunteers.

POLICY IMPLICATIONS

At the level of social policy, there are numerous opportunities to advocate for individuals facing the triple challenges of old age, mental health problems, and membership in a cultural minority. Culturally competent social workers can engage these issues in several ways. A starting point might be lobbying insurance providers, including providers of Medicare services, for parity in reimbursement for physical and mental health services. Under many insurance plans, reimbursement rates for mental health treatment are not comparable with those for treatment of physical diseases and disorders. Medicare, for example, elicits a copayment of 50 percent for outpatient mental health services. By comparison, outpatient medical treatments for physical health problems have only a 20 percent copayment (Takeuchi and Kim, 2000). Since socioeconomic resources limit many elders of color from accessing treatment, achieving parity in reimbursement would greatly reduce this barrier, at least for

those elders who have coverage from Medicare or other insurance plans.

The policy implications of cultural competency also include an attentiveness to laws that may further restrict the access of elders of color to treatment and social services. One example is California's Proposition 187. Passed in 1994, the act was intended to make undocumented immigrants of all ages ineligible for state-funded health and mental health services. Though later declared unconstitutional and never fully enforced, this measure decreased service usage for both illegal and legal immigrants who feared they might unintentionally implicate undocumented friends or relatives through their connection with the health care system (Fenton, Catalano, and Hargreaves, 1996). Social welfare policy developed from a perspective of cultural competency must take into account the needs of immigrant as well as native-born elders. Social workers must be aware of legislation, such as Proposition 187, that would render culturally competent policy impossible.

Because extending social policies to cover immigrant elderly persons implies that there will be fewer resources available for native-born elders, policy makers are likely to encounter some opposition. As many will recall, Proposition 187 sparked a contentious national debate. In the bigger picture, however, policy makers may encounter controversy in simply trying to provide resources for elderly people. Elderly people in our society, and particularly elders with mental health problems, are often victims of numerous (and untrue) negative stereotypes. These stereotypes include the notion that old age is a period of inevitable decline, as well as the perception that all elderly people are set in their ways and unable to change (Golden and Sonneborn, 1998). Consequently, some might argue that investment in social services for the elderly is a lost cause and that our society's resources should be directed at children or younger adults.

CONCLUSIONS AND FUTURE NEEDS

As the proportion of the population that is elderly continues to grow, so does the percentage of Americans identifying themselves as belonging to an ethnic or racial minority group (Abramson et al., 2002). It is thus critical, now more than ever before, that social workers respond to the needs of elders of color. Responses should focus on the provision of culturally competent care for the mental health conditions that some elderly adults experience. Depression, anxiety disorders, and dementia are among the most common.

Varied work efforts are needed to achieve culturally competent care. These include developing diagnostic tools that are culturally sensitive and designing programs that integrate an understanding of culture into treatment.

Such programs should also pay particular heed to cultural mores concerning aging and mental health. Programs such as RESPECT, with its innovative utilization of peer advocates to bridge cultural divides, serve as models that other service providers can implement as they work to ensure cultural competency (Yee, 1997). In addition, the creation of culturally competent care requires advocating on a policy level for the allocation of resources to the programs that care for elders in a culturally competent manner. Striving for cultural competence in mental health care for elderly people presents a challenge to society and gives social workers the opportunity to actualize some of the profession's most cherished values, diversity and an emphasis on client strengths. ■

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NOTE

1. The term "cultural minority" will be used throughout this article to refer to Americans who identify themselves as belonging to a racial, ethnic, or religious minority group.

ABOUT THE AUTHOR

ELIZABETH BOWEN is a second-year clinical student at the School of Social Service Administration, specializing in older adult studies. She is a graduate of the University of Pittsburgh, where she majored in psychology and nonfiction writing. Currently an intern in the Department of Psychiatry at the University of Chicago Hospitals, Elizabeth hopes to work with elderly people following graduation. Her social work interests include aging and mental health, cultural competency, religion and spirituality, and international social work.

Exploring Microenterprise Programs: Self-Employment in Disadvantaged Communities

By Marius Ioan Dancea

Poverty continues to plague America's urban communities. Many proposals have sought to address the issues related to poverty. Microenterprise programs are one such approach. Microenterprise programs design training programs that educate urban poor on how to establish and operate small businesses and structure microcredit activities that provide minimal loans to prospective or small business owners. By focusing on particular sites, such as ACCION Chicago, this article analyzes two aspects of microenterprise programs to argue that if such programs are to benefit those truly in need, they must simultaneously provide training and microcredit activities to the urban poor.

Microenterprise programs seek to increase self-sufficiency and self-employment among the poor, those on welfare, and the unemployed. However, not all microenterprise programs use similar strategies. Some programs focus on training activities designed to educate individuals on how to establish and operate small businesses. Alternatively, other microenterprise programs, such as those provided by ACCION Chicago, focus only on microcredit activities. Microcredit provides small loans to existing businesses or to individuals who seek to establish and operate new small businesses. This article analyzes the activities of one microenterprise agency, ACCION Chicago, using that paradigm as a means to better understand microenterprise and microcredit programs generally. The current study will also use this focus to discuss the social problems that microcredit programs attempt to address, the targeted solutions proposed, and the challenges that microenterprise initiatives confront.

MICROENTERPRISE AND MICROCREDIT PROGRAMS

Microenterprise programs depend on the formulation of strong relationships

between lenders and borrowers; those relationships also help to ensure low default rates. Virtually all microenterprise programs provide training to low-income individuals, and once they have been trained, some are then referred to partner microcredit programs. However, some individuals do not benefit from microcredit programs because their credit history or income makes them ineligible to borrow (Servon, 1999). Lisa Servon argues that, in order to be most effective in the fight against poverty, programs should increase human capital while simultaneously increasing the ability of disadvantaged groups to access financial capital. There are two types of microenterprise programs. Some microenterprise programs focus only on microcredit activities, while other programs focus on both microcredit activities and training practices. ACCION Chicago, for example, focuses on microcredit activities to increase financial capital (i.e., money). Alternatively, the Institute for Social and Economic Development focuses on microcredit activities as well as training to increase human capital (i.e., skills). Both of these strategies are important in aiding disadvantaged individuals to become more self-sufficient.

Some researchers argue that lack of access to credit is a problem that cannot be cured with training activities alone, but must be solved by improving individuals' credit (e.g., Raheim, 1997). Microcredit programs partially address this problem by providing loans to small business owners who have been previously unable to access traditional forms of credit. Servon (1999) finds that funding for microenterprise programs is usually a result of relationships with banks, private-sector corporations, churches, community colleges, other microenterprise programs, community-based organizations, and government agencies at the local, state, and federal levels. In particular, ACCION Chicago provides loans of up to $35,000 to businesses that have been in operation for more than 1 year. Loans of approximately $15,000 are made to businesses in operation less than a year. The terms of these loans are typically from 2 months to 4 years. Loans are typically covered by collateral or guaranteed by a qualified cosigner. In other words, microenterprise lenders do not furnish these sorts of loan guarantees as part of their services. Notably, ACCION Chicago does not furnish these sorts of loan guarantees as part of their services.

In order to obtain loans through ACCION Chicago, applicants must have income sufficient to honor payments on the new debt, must live and operate the business within Illinois, must use the loan to engage in legal business activity, and must be at least 18 years old. The interest rate on these loans depends on credit risk and history of the business. Rates can range between 10.6 percent and 16 percent for a fixed-rate loan. The turnaround time to

receive a loan varies, depending on qualifications, but a pre-qualification determination can be made within one week. Loan approval and the loan-closing schedule depend on the timely submission of requested documents. The effectiveness of ACCION Chicago's microcredit program can be seen in its success rate. Over 90 percent of ACCION Chicago's loans have been repaid (ACCION Chicago 2002; Jonathan Brereton, chief operating officer, and Peter Redovich, associate, ACCION Chicago, personal communication, November 21, 2003).

WHAT'S THE PROBLEM?

In 1997, one billion people around the world lived in poverty (Woodworth, 2000). Concentrated pockets of poverty also continue to plague the United States. This is particularly the case in urban areas (Tinker, 2000). Very few community strategies have been effective at alleviating the economic barriers faced by residents of these low-income pockets (Raheim, 1997). Warner Woodworth argues that the underlying cause of poverty is lack of wealth, asserting that the individual, not government, is responsible for creating wealth. This argument is problematic, however, because it does not take into consideration the availability of employment. Furthermore, regardless of the willingness of welfare recipients to work, there is no way to reduce the number of people in poverty until increases in employment enable those in need to build wealth or until other means of acquiring wealth are provided (Pfleger and Bennett, 1995).

Employment opportunities allow individuals to build assets. Effective strategies to increase self-sufficiency (as outlined in such policies as Temporary Assistance for Needy Families) must focus on increasing individuals' assets. This focus on building assets, in turn, increases national levels of wealth (Pfleger and Bennett, 1995; Raheim, 1997). But assets alone are not sufficient to address persistent economic barriers. One strategy of overcoming economic barriers is community development. Ronald Ferguson and William Dickens (1999) point out that in order to facilitate growth of community development (that most argue cannot be separated from economic development), "neighborhood-based organizations could be instruments of political and economic empowerment, with a heavy emphasis on internal production and self-sufficiency as an economic development strategy" (p. 18). The individual benefits from strong neighborhood organizations because they not only create networking and support opportunities for low-income individuals, but these organizations also assist individuals by teaching how to build assets. Thus, the most effective way of increasing individuals' wealth, and thus national wealth,

is to provide programs that pave the way of wealth creation and maintenance.

For poor women (especially poor single mothers), barriers, such as lack of child care, decreased access to transportation, low education, and low job skills, further limit employment opportunities (Tinker, 2000). In addition, juggling parenthood with employment intensifies economic isolation, and such demands further impede individual economic growth (Tinker, 2000). For recent immigrants (especially undocumented immigrants) and refugees, a number of factors, including language and cultural differences, may make mainstream employment inaccessible (Raheim, 1997). The factors are further complicated by the flight of entry-level jobs to other countries, where cheaper labor and more lenient labor laws only serve to further deepen the poverty in American urban areas. Economic isolation also results from the pressures that many companies place on entry-level employees to discourage them from organizing. Such pressures can include elimination of health care benefits in order to increase profits and threats to shut down the company if employees attempt to exercise rights to organize (Virginia Parks, personal communication, November 20, 2003).

For members of oppressed or marginalized groups, self-employment (such as starting a new business) can provide a level of flexibility and freedom. Self-employment may also result in a living wage and enable individuals to earn a higher wage than the one that could be earned in the mainstream labor market (Raheim, 1997). In fact, for some families, self-employment activities may be the sole means of survival. According to Salome Raheim (1997), a study finds that approximately 500,000 former welfare recipients were supporting themselves through self-employment activities. However, there are also significant barriers to self-employment as well, in particular, to those people receiving public aid. Over 100,000 women were supporting their families through a combination of self-employment and welfare benefits (Raheim, 1997).

According to Raheim (1997), the primary barriers to self-employment include lack of business knowledge and skills (human capital), as well as lack of access to various types of capital (such as financial). In terms of human capital, low-income people from disadvantaged groups are less likely to have access to the information resources that would make such knowledge and skills reachable (Raheim, 1997).

Interestingly, the basic forms that define community development (human capital, physical capital, and social capital) are the same types of capital missing from those who need them most, and the absence of this capital impedes their growth. Notably, theorists such as Alejandro Portes (1998) and James DeFilippis (2001) argue that social capital is essentially created at the individual level; networks are made of individuals, but can be aggregated and

measured at the community level. In particular, Portes writes, "the greatest theoretical promise of social capital lies at the individual level—exemplified by Bourdieu and Coleman—there is nothing intrinsically wrong with redefining it as a structural property of large aggregates" (Portes, 1998, p. 15). DeFilippis concludes that social capital should not be "divorced from capital (in the literal economic sense), stripped of *power* relations, and imbued with the assumption that social networks are win-win relationships and that individual gains, interests, and profits are synonymous with group gains, interests and profits" (2001, p. 800). DeFilippis (2001) points to community-controlled capital and argues that the root of the problem lies in the lack of economic capital. He argues that the absence of available economic capital should receive primary focus, and he eschews the strategy of building economic capital through social capital. Therefore, Portes and DeFilippis shed light on how the complexities of the various types of capital have great relevance for microenterprise programs; these programs constantly try to seek out the best methods to negotiate capital.

Raheim (1997) argues that lack of access to physical capital might be the biggest barrier to people receiving public assistance, because it limits opportunities for business success. Banks are reluctant to finance the business ventures of low-income people because of poor credit history or lack of collateral. Moreover, the loans needed to finance many self-employment activities are seen as too small to be profitable for many banks. Lack of capital also limits the types of businesses that can be created. Woodworth (2000) argues that even a small loan could make a big difference in low-income communities, particularly in third-world nations. Servon (1999) finds that microenterprise programs depart from traditional attempts to address the problem of persistent poverty through economic development. As compared to either traditional economic development or poverty alleviation strategies, microenterprise programs are more flexible, more creative, and more oriented to the context in which they operate. Indeed, the microenterprise strategy offers hope that there is room to operate within the confines of the policies now in place.

ACCION CHICAGO'S SOLUTION TO THE PROBLEM

There is much evidence to suggest that microenterprise programs provide a trickle-up approach to the battle of poverty (Fairley, 1998; Pfleger and Bennett, 1995; Raheim, 1997), but not all microenterprise programs have the same strategy. Some microenterprise programs provide services that focus on training and interaction with the clients. Other programs, such as those of ACCION Chicago, focus on microcredit activities. In order to understand how ACCION Chicago assists the impoverished with its programs, two

ACCION Chicago associates were interviewed together. One was a current chief operations officer and the other was a former employee. Both noted that by providing training and financial services, ACCION Chicago is giving low-income individuals the tools (i.e., business skills and financial capital) to compete in the mainstream economy. This focus on providing both training and services contradicts ACCION Chicago's mission because according to its mission, ACCION only provides microcredit activities. Thus, they argue that capital and training should go hand in hand. That is, if programs are to be most effective in helping the poor and unemployed overcome the barrier of economic isolation, they should focus on training services while simultaneously providing access to capital (Jonathan Brereton, chief operating officer, and Peter Redovich, associate, ACCION Chicago, personal communication, November 21, 2003). Their views are in agreement and coincide with research showing that although training activities provided by microenterprise programs should be combined with credit assistance, lack of access to financial capital is a major barrier to individual economic prosperity. Limitations on access to credit deserve a closer examination to determine their role in the training-credit relationship (Raheim, 1997).

Often, microenterprise programs like those of ACCION Chicago have similarities with microenterprise programs in third-world countries. For example, Woodworth (2000) finds that to empower the third-world poor, small businesses are created through village banking. In this process, no collateral or credit history is required. When a group borrows money, each member of the group is individually liable for the entire amount of the loan. Woodworth noted that social pressure and trust create powerful incentives (such as group responsibility, accountability, and shame from the community) for the group to pay back the loan; members do not want to be the sole individual responsible for repayment. The structure of these microenterprise programs in third-world countries does not necessarily mirror those in the U.S. If the practices and programs at ACCION Chicago are analyzed, differences become apparent. ACCION Chicago requires collateral or a cosigner in order to prequalify for the loan. The microenterprise lenders in third-world countries definitely do not require such steps. In the U.S., such requirements create a creaming effect, such that the system favors those able to find cosigners and collateral. As a result, the poorest and least skilled are cut off by this strategy.

ACCURACY OF GOAL-STRATEGY MATCH

ACCION Chicago's proposed solution to the problem of poverty is to provide

"credit and other business services to small business owners who do not have access to traditional sources of financing" (ACCION Chicago, 2002, p. 2). However, ACCION Chicago does not target individuals who are not business owners. Rather, they provide loans for existing and prospective owners but do not provide services to any other type of clients. Microenterprise programs serve two types of clients: the larger, more advantaged pool that is ready to borrow, and the smaller, less-advantaged pool that needs more training. For both of these groups, there is pressure to control loan losses and to keep the cost of training down. Such pressures reinforce the tendency to lend to better-educated, more affluent clients (Bates and Servon, 1996). ACCION Chicago falls into the same trap as most microenterprise programs: "[they] do more to help those who exist at the margins of the mainstream economy than those who are completely cut off from the economic mainstream" (Servon, 1997, p. 166). As a result, microcredit makes only a small impact on the poorest communities.

CHALLENGES TO THE INITIATIVE

There are a variety of factors that impede the success of microcredit programs like those at ACCION Chicago. In her review of the research, Joanne Fairley (1998) points out six specific factors that complicate the success of microcredit programs. First, "microcredit institutions work with a safe target group—not the poorest—because of funding accountability concerns" (Fairley, 1998, p. 2). Second, because the poor are stigmatized, many microcredit lenders distrust the poorest of the poor. Third, there is a huge time commitment when trying to assist the poor. Fourth, policies such as licensing requirements and a fluctuating economy harm the growth of small businesses and savings. Fifth, the poorest of the poor become uninterested and uninvolved because of the many risks. Sixth, policies that would provide alternative forms to inflexible microcredit criteria for the poorest of the poor are absent. In addition to these six factors, Raheim (1997) notes that small amounts of loans will facilitate more small businesses than demand will support. Also, he contends that lack of adequate health insurance (e.g., major medical expenses) can easily bankrupt uninsured small business owners because small businesses often do not generate enough income to assume health insurance costs.

SOLUTIONS TO CHALLENGES

Joanne Fairley (1998), Solome Raheim (1997), and Lisa Servon (1999) provide

us with important lessons on how microcredit programs can facilitate economic growth and success of small businesses that belong to low-income individuals and communities. First, at the individual level, microcredit programs should target those who are marginalized and excluded from economic opportunities by attracting and providing more training classes. Second, at the institutional level, microenterprise programs should be funded in such a way so as to grant waivers to participants for at least 2 years in order to eliminate such barriers as health insurance that have the potential to bankrupt a small business. Because self-employers often lack financial stability, giving microloans to them is not enough. The state should provide special care to these newly developing microenterprise programs in order to aid in the potential success of the small business. This is especially the case during the first 2 to 3 developing months of small businesses. This would shield fragile small businesses against undercapitalization effects, such as unanticipated medical emergencies.

Third, at the national level, the U.S. government should consider increasing funds to self-employment development programs (e.g., microcredit and training programs) and provide more self-employment options at job placement sites. Also, Raheim (1997) concludes that self-selected participation appears to be more effective and empowering when it attempts to target individuals based on beliefs about their potential for success. It is also important to note that the Community Reinvestment Act (CRA; 12 U.S.C. § 2901) requires banks to work with microenterprise programs, such as those of ACCION Chicago, in order to meet the requirements set by the government (Brereton and Redovich, personal communication, November 21, 2003). Thus, evidence suggests that investing in the poorest communities is highly selective, but has great potential to increase both the self-sufficiency of individuals and the basic forms of community development, such as physical capital, human capital, and social capital.

There have been few evaluations of the effectiveness of microenterprise programs. One exception involves the only experimental test of the impact of microenterprise programs conducted by the Unemployment Insurance Self-Employment Demonstration (UISED). UISED analyzed data from microenterprise programs in Washington and Massachusetts (Schreiner, 1999). The UISED did not reveal the best design for microenterprise, nor for programs regarding social investment. However, Mary Schreiner (1999) concludes that while UISED did shorten unemployment spells, other changes had small impacts and the most disadvantaged individuals did not choose to participate.

CONCLUDING REMARKS

Research suggests that microcredit programs can help to alleviate poverty when they are closely connected with training programs. However, microenterprise programs are not the only answer to the problem of poverty. This is particularly true of the problems facing those most in need. Nevertheless, evidence clearly shows that effective strategies to reduce welfare dependency must focus on increasing wealth through self-employment (Raheim, 1997; Servon, 1999). The government's involvement in the welfare state need not increase in order to curb poverty. Rather, more strategies are needed that use microenterprise programs effectively to target the poorest of the poor. ■

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ABOUT THE AUTHOR

MARIUS IOAN DANCEA holds a B.A. in political science with a minor in social work from Northeastern Illinois University. He is currently an A.M. candidate in the School of Social Service Administration at the University of Chicago. His research interests include community development, particularly the impact of microenterprise programs on low-income communities.

Separation of Incarcerated Mother from Child: The Impact on Childhood Development and the Call for Greater Clinical and Policy Interventions

By Alana Gunn

Many children live in physical and emotional poverty during and after the incarceration of their mothers. This deprivation can impact their academic performance, ability to handle stress, receive and give love, or abstain from delinquent and violent behavior. This article argues that the separation of mother and child, as a result of imprisonment, can have a detrimental impact on a child's life. Social workers and policy makers must implement alternatives to policies and practices that perpetuate harm to these victims.

While the overall prison population in the United States has swelled, the rise in the population of incarcerated women has been most alarming. From 1990 to 2002, the number of women in state and federal prisons increased 121 percent, to 97,491 from 44,065, while the number of men rose 84 percent in that period from 729,840 to 1,343,164 (Butterfield, 2003). Also significant to note is that the Bureau of Justice Statistics (2000) reports that over 75 percent of female inmates are single mothers, and 66 percent of their children are under the age of 18. In this population, 75 percent of the women had legal custody of their offspring at the time of arrest (Enos, 1997). These statistics indicate that the majority of women in prison are not only mothers but also the primary caregivers of their children at the time of arrest. Therefore, it is imperative to examine the incarceration of mothers, because their imprisonment will certainly have an overwhelming impact on the lives of their children. To fully contextualize why these children are at risk, we must briefly address the lives of their incarcerated mothers and the circumstances in which these children grow up.

THE LIVES OF INCARCERATED WOMEN WITH CHILDREN

In general, incarcerated women face a great deal of adversity, but females of color make up most of the prison population. Only 26 percent of the U.S population is nonwhite and non-Hispanic (Morash and Schram, 2002). By contrast, 46 percent of the females behind bars are African American, and 15 percent are Latina (Enos, 1997). Almost 66 percent of the female incarcerated population are women of color; clearly, they are overrepresented. This situation is compounded by the lack of education among incarcerated women and the absence of employment opportunities in their communities. Sixty-two percent of incarcerated women have less than a high school education (Watterson, 1996). Generally, long periods of unemployment and poverty are a way of life for these single mothers; prior to incarceration, they earn an average of $3,000 to $10,000 a year (Watterson, 1996). This suggests that incarcerated mothers leave behind children who face serious economic hardships.

While financial hardship poses a great barrier to their well-being, these women also experience emotional and physical afflictions that are just as damaging. Eighty-five percent of all the women in prison have experienced physical or sexual abuse, either as children at the hands of adults or as adults from their mates (Watterson, 1996). In a survey done by the American Correctional Association, empirical evidence reveals that over half of female inmates questioned reported physical abuse, and 36 percent reported sexual abuse (2000, in Watterson, 1996). Unfortunately, abusive experiences can lead women to turn to drugs and alcohol. In turn, substance abuse can lead to trouble with the law (Watterson, 1996).

When considering the crimes that these women commit, it is important to note that approximately 25 percent of women in state prisons are serving sentences for violent offenses (Watterson, 1996). The remaining three-fourths of women behind bars committed non-violent drug offenses to support a drug habit or their families. Such offenses include petty theft, welfare fraud, larceny, forgery, and prostitution (Watterson, 1996). As is evident from the frequency of experiences of poverty, unemployment, and physical and sexual abuse, these inmates have suffered greatly. Through an examination of their lives, it is possible to see how the intersection of race, class, and gender plays a major role in leading incarcerated women to their present circumstances. Such circumstances are also significant factors in the present circumstances of their children.

THE LIVES OF CHILDREN OF INCARCERATED WOMEN

As of October 2003, over 2 million American children had an incarcerated parent; approximately 10 million have experienced the imprisonment and separation from a parent at some time in their lives (San Francisco Partnership for Incarcerated Parents, 2003). This separation from a parent has more than just a physical impact on these 10 million children. Separation can also have tremendous consequences for children's psychological development (Reed, 1997). To fully understand the emotional and mental ramifications of separation, we should examine the attachment between mother and child.

ATTACHMENT BETWEEN MOTHER AND CHILD

Attachment is a developmental process in which an individual forms a specific emotional bond with another (Newman and Newman, 2003). The attachment or bond formed between mother and child can have a great impact on the consequent stages of child development (Hazan and Zeifman, 1994). This bonding process is particularly important to children in unstable environments filled with crime, poverty, and violence. Unfortunately, such environments are characteristic of many of the communities where children of incarcerated mothers are raised (Watterson, 1996). When a child's mother becomes imprisoned, not only is a child left in the adverse environmental circumstances, but according to Diane Reed (1997), the bond that has been created becomes damaged. A parent's absence and severance of the parent-child bond may cause children to act out or behave delinquently (Reed, 1997).

The impact of maternal separation from a child is clearly illustrated in the article entitled, "Like mother, like daughter" (Locy, 1999). In Toni Locy's report, an 18-year-old African-American girl shares her experiences as a child of an incarcerated woman. Star, 18, follows in the footsteps of her mother, taking up the same lifestyle: school truancy, teen pregnancy, drug use, and later, imprisonment (Locy, 1999). She was separated from her mother at the age of 11, but the desire for a bond between child and mother could not be easily broken (Locy, 1999). Because she could not satisfy her emotional and physical needs, she started drinking, stealing, and being promiscuous, just like her mom (Locy, 1999). While it is important to understand the psychological effects of maternal incarceration on a child's development, it is also essential to comprehend how children are affected by the larger society and environment.

APPLICATION OF SYSTEMS THEORY

The systems theory conceptualizes the importance that factors, such as family, community, school, or society, can play in the development of the individual and his or her consequent life activities (Newman and Newman, 2003). "The system can not be wholly understood by identifying each of its component parts... the relationships of those parts make for a larger coherent entity" (Newman and Newman, 2003, p. 84). Through an application of systems theory to the life circumstances of Joyce Dixson and her sons, it is possible to clearly demonstrate the role that the environment plays in shaping a child's ability to cope.

In 2001, Joyce Dixson, founder and director of Sons and Daughters of the Incarcerated (SADOI) gave a personal account of the hardships resulting from her incarceration (Joyce Dixson, personal communication, March 9, 2001). In August of 1976, Ms. Dixson was convicted of killing her husband and imprisoned for 17 years. Ms. Dixson described her husband as the sort of person who could "beat up old people and sell drugs to young kids" (personal communication, March 9, 2001). While in prison, Dixson focused her energies on acquiring an education and transforming her life. She became the first incarcerated woman to earn a bachelor's degree from the University of Michigan. After receiving this degree and enduring 17 years of arduous struggles with legal appeals and letter-writing campaigns, an appellate court overturned her conviction. But for Ms. Dixson, the victory was bittersweet: her two sons, who did not have any contact with her while she was in prison, were grown. The two young boys whom she left at 6 and 12 years of age were now 23 and 29 years old. The traumatic experiences endured during their mother's incarceration were a direct result of the separation (personal communication, March 9, 2001).

"Children who played with my kids previous to my incarceration, no longer wanted to be bothered with them," said Dixson (personal communication, March 9, 2001). Neighbors ceased to welcome the children of a "prison mommy" into their homes (personal communication, March 9, 2001). In essence, the children were ostracized from their community and were made to feel like criminals themselves. This ostracism was also evident at school. Ms. Dixson was constantly informed that her older son frequently fought other children in the streets and on school grounds. Classmates excluded her sons from participating in a variety of activities, including eating together at lunch and involvement in group activities (Joyce Dixson, personal communication, March 9, 2001).

When she was incarcerated, her sons were at a very impressionable stage. Peer and clique acceptance can be crucial to the development of children. Barbara and Phillip Newman (2003) note the importance of peer groups in stating that "[Cliques] hang out together, know about each other's families, plan activities together....Within cliques, intimate information is exchanged" (p. 308). This peer recognition is an essential component of childhood development. Not gaining approval from peers can create feelings of alienation and a lack of belonging to a group (Newman and Newman, 2003).

While the children were experiencing these events in interactions with their peers, they also faced difficulties resulting from the way in which their school chose to address their problems. Dixson explained that, although there were counselors for children experiencing divorce or abuse, no professionals in the school were trained to deal with issues facing children of incarcerated parents (personal communication, March 9, 2001). School officials did not recognize the unique problems created by separation of a child from an incarcerated parent. Instead, officials responded to the situation as they would to any loss of a parent (personal communication, March 9, 2001). Failure to recognize the unique problems confronted by these children complicated their needs and silenced their voices (personal communication, March 9, 2001).

The presence of poverty and violence in the community can also play a role in a child's development (Newman and Newman, 2003). The children of incarcerated mothers are disadvantaged, not only because of the loss of their mother, but because of their economic situation. The children typically live in poverty before, during, and after their parent's incarceration (Reed, 1997). Because the average annual income of a single mother is between $3,000 and $10,000, poverty is a substantial obstacle (Watterson, 1996). "In these communities, the loss of an economic base with few people in stable, high-status occupations leads to takeovers by gangs and other organized criminal activities, especially drug traffic" (Newman and Newman, 2003, p. 284). In these impoverished communities, these children experience a lack of positive role models and support systems. Because of the presence of gangs and other criminal activities in their communities, adolescents become more susceptible to experiencing violence, either as a victim or a perpetrator (Newman and Newman, 2003).

Community factors such as these can significantly increase the chances that children of incarcerated parents will also commit criminal activities. Data from the Bureau of Statistics indicate that children of incarcerated mothers are five to six times more likely than their peers to engage in delinquent behavior, such as alcohol or drug use, truancy, and theft (Reed, 1997). All of the afore-

mentioned environmental factors can aggravate the situations of these children and cause harm to their psychological development (Reed, 1997). The stigmatization faced by children of incarcerated parents can also be perpetuated by family members. Joyce Dixson's sons went to live with their maternal grandparents when she was imprisoned. The grandparents told her children their mother was dead; they eventually learned that was false (personal communication, March 9, 2001). This situation is entirely different from one involving an actual death of a loved one. For a child who does not know what has happened to his or her mother, the ambiguity can be extremely devastating. Clearly, it was painful for her sons to hear their family members denying the life and existence of the mother, and virtually the origin and value of theirs.

An adolescent female with an incarcerated mother told a similar story of hardships endured because of an unsupportive family structure. Leah (the name has been changed to protect her identity) is a 13-year-old girl who was told to forget about her incarcerated mother (personal communication, March 9, 2001). Members of her family constantly reminded her that "the apple did not fall far from the tree," causing her to distance herself physically and emotionally from the woman who cared for her from birth (personal communication, March 9, 2001). Leah was led to believe that her mother's criminal activity was evidence of her own potential to behave pathologically, and this caused a great deal of trauma in a situation that was already devastating (personal communication, March 9, 2001). Family structure and community can exacerbate the problems faced by children with incarcerated parents, but the community and family can also provide important supports and encouragement.

In contrast to the other examples discussed, a highly supportive family structure greatly facilitates the ability of a child to cope with a mother's imprisonment. Adrian (her name has been changed to protect her identity) was 12 years old when her mother was sentenced to 10 years in a correctional facility for conspiracy to sell drugs. Like many adolescents at this age, Adrian was at a crucial period in her life. The love and presence of her mother seemed to be necessities (personal communication, March 9, 2001). During her mother's incarceration, Adrian lived with her maternal grandmother, who became a great source of comfort. Adrian's story differs from those reported above because she was encouraged to love and remain in contact with her mother (personal communication, March 9, 2001). Adrian was taught that, although her mother committed an unlawful deed, this act did not diminish her mother's value as a person or Adrian's value as

her daughter. In church and at other community activities, when Adrian's mother's name was mentioned, it was more of a way to remember her important place in Adrian's life than as a means of degrading her mother's value (personal communication, March 9, 2001). This method of identifying with her mother helped Adrian to develop positive esteem and to cope with her mother's incarceration. Although Adrian still sought counseling to deal with her mother's absence, she was supported throughout the process. The familial nature of these interactions allowed Adrian to thrive in spite of her mother's incarceration. Such a nurturing environment is ideal, but not all children have that good fortune.

In the event of parental incarceration, if children cannot be placed with a suitable and stable relative, children enter the foster care system. "Unlike most children who enter child protective services system due to parental neglect, children of arrested parents become dependents of the juvenile court and are subsequently placed in foster care if no relative is available" (Reed, 1997, p. 155). "Fundamentally, the kids are punished along with the mother as they are shuttled through an odyssey of makeshift care arrangements, separated from siblings, yanked out of schools, and left alone to struggle with the turmoil of disrupted lives" (Huie, 1993, p. 2). However, whether placed in foster care or with relatives, they will experience adversity. The school, community, and even family members can have far-reaching effects on the child's development.

THE ROLE OF SOCIAL WORK IN PROMOTING CHANGE

Social workers can play an important role in addressing the dilemmas faced by the children of incarcerated mothers. In the schools, social workers can promote sensitive environments where counseling opportunities can facilitate a child's healing. In discussing students' unique concerns, social workers can tailor intervention approaches to meet the needs of this special population. The dilemmas of these children should be addressed differently from those of a child suffering from divorce or the death of a parent. School social workers should also serve as a resource, connecting the child with appropriate services in the community. In addition, social workers can also facilitate awareness of these issues among other school staff, such as teachers, counselors, administrators, and other students.

As greater numbers of economically disadvantaged parents experience incarceration (Watterson, 1996), it is important to increase the dialogue concerning the many issues that contribute to disadvantage and incarceration.

Academia should promote the study of imprisonment through a more comprehensive curriculum. Research should continue to investigate the rise of incarceration, examining the impact of this trend on families and communities. The prison industrial complex must also be evaluated, especially with respect to how it affects the social work discipline.

Along with promoting awareness, social workers should expand their advocacy efforts to include participation in programs that facilitate visitation between children and their incarcerated mothers. The need is great. A recent study by the San Francisco Partnership for Incarcerated Parents reports that when "the Federal Bureau of Justice Statistics conducted its own survey, 54 percent of mothers in state prisons reported never having a single visit from their children" (2003, p. 32). One promising effort is run by the Children with Incarcerated Parents Program (CHIPP) at the New York City Administration for Children's Services. CHIPP administers a program that enables children in the foster care system to visit their mother's incarcerated at the Riker's Island Women Facility. The program is run by social workers who also offer counseling services to the visiting children and their mothers. Programs such as these are extremely important for counteracting the effects incarceration on children. Social workers can play an essential role in addressing these issues.

THE ROLE OF PUBLIC POLICY IN PROMOTING CHANGE

Like social work, public policy is essential in promoting change. Current laws and policies, such as the Federal Adoption and Safe Families Act (ASFA), must be challenged. ASFA gives states the authority to begin terminating parental rights if a child has been in foster care for 15 out of the past 22 months. For children under 3 years of age, states can begin the termination proceedings after just 6 months (San Francisco Partnership for Incarcerated Parents, 2003). With the average term for state prisoners being 2 and a half years, it is evident that this adoption policy creates requirements that are problematic for many incarcerated mothers to meet (San Francisco Partnership for Incarcerated Parents, 2003). Even if a mother is released before the termination proceedings begin, she must meet the requirements of a reunification plan. Such a plan requires her to complete a drug treatment program and secure a stable residence within the time the time regulations (San Francisco Partnership for Incarcerated Parents, 2003). Under the new welfare reforms, any individual with a felony drug conviction is ineligible for benefits, including housing (San Francisco Partnership for Incarcerated Parents, 2003). This diminishes the

chances of meeting the requirements. While these conditions aim to create a stable and secure environment for the child, they can be difficult to satisfy within the inflexible time frame. This rigidity, in turn, perpetuates an additional form of punishment; incarcerated mothers do not receive the opportunity to prove themselves capable of regaining custody of their children.

Concerns have been raised regarding whether some incarcerated mothers, such as those convicted of murder, pose a threat to their child's well being and, thus, should not have visitation rights (Watterson, 1996). Kathryn Watterson (1996) reports that while nonviolent drug offenses make up the largest proportion of crimes committed by women, 30 percent of incarcerated women do get charged for committing violent crimes. Among women incarcerated for violent offenses, 66 percent knew the victim. It is also noteworthy that a study reported by Watterson (1996) finds 90 percent of the women imprisoned for murder in New York State murdered men who had long histories of abusing them. Because the vast majority of incarcerated women commit crimes as a result of defending themselves or their children from a paramour, husband, or ex-husband (Watterson, 1996). Thus, it is important that murder cases be examined on a case-by-case basis in order to understand the specifics of the crime and the appropriate punishment. Murder should not be the determinant for eliminating visitation rights; these cases should be examined individually.

More programs are needed to provide consistent visitation. While programs such as these have been created, they are too few in number and too limited in scope. Programs such as Mothers and Their Children (MATCH) aim to bring the child and mother together every weekend and holiday in a nonthreatening, somewhat jovial environment. Prison MATCH volunteers use facilities in San Francisco County Jail No.7 to create a nursery school. Similar centers are present in 14 facilities across the country, providing comfortable, toy-filled environments in which mothers and children interact (Huie, 1993). The Prison MATCH program in North Carolina also offers visitation between mothers and their children. They have an 8-week parenting skills class, in which incarcerated mothers discuss relevant issues, such as conflict resolution, the substance abuse cycle, and prenatal and infant care (Prison MATCH of North Carolina, n.d.).

Another creative initiative is The Girl Scouts Behind Bars program. This endeavor unites children with their incarcerated mothers on a weekly basis to engage in activities reminiscent of a Girl Scouts model. Activities focus on arts, crafts, math, sciences, fitness, and health, as well as on more important topics, such as self-esteem, drug abuse, and relationships (Moses, 1995). Programs

such as these try to ameliorate the circumstances of both the mother and the child. Such programs recognize that these inmates are also parents. More of these programs are needed if the relationships between children and incarcerated mothers are to be saved.

In addition, policy changes should be sought through greater advocacy and the creation of broad coalitions. For example, the Illinois Task Force for Children of Prisoners, Children of Promise has brought together administrators from the Illinois Department of Corrections, faith-based organizations, substance treatment facilities, skills development and job training programs, and child advocacy organizations. The coalition discusses the needs of these children and the ways to create policy alternatives. Their mission, as stated by Lydia Watts of the PUSH Coalition, "is to prevent the harm done to children by parental incarceration, and promote healthy relationships between children and their parents through implementing policies and providing needed services and programs" (personal communication, November 21, 2003). More such initiatives are needed to promote interagency cooperation on these issues.

In the efforts to raise awareness of the problems facing children of incarcerated mothers, dialogue must focus on transforming theories and suggestions into practice. Poor families of color are disproportionately affected by this mass incarceration and separation. The family structures disrupted and the emotional bonds severed are primarily those between impoverished mothers of color and their children. If the effects of such separation are not addressed in this population, they may have a detrimental impact on the quality of our society as a whole. It is crucial that the psychological, social, biological, and cultural aspects of incarceration be understood. The impact of incarceration on the bond between parent and child must be elucidated. So too, the role of social work and public policy initiatives will also be essential. This process of change will be challenging, but the task is both imperative and promising. ■

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ABOUT THE AUTHOR

ALANA GUNN is a Bronx native. She is pursuing a dual degree with the School of Social Service Administration (SSA) and the Harris School of Public Policy Studies. At the Harris School, she is a McCormick Tribune Child and Family Fellow. At SSA, she is in the family support specialty. Alana Gunn received a B.A. in urban studies from Vassar College, where she wrote a thesis on incarcerated mothers. She continues to work on research and policy in this field.

The Effects of Chronic Poverty on South African and American Adolescent Psychosocial Development

By Meegan M.D. Bassett

Although little research exists on the effects of chronic poverty on adolescents, it is clear that the results of chronic childhood poverty have lasting effects on children's psychosocial development. For Black adolescents in South Africa, significantly more destitute living conditions, the AIDS crisis, and the relatively recent experiences of apartheid may shorten their adolescence and make positive developmental task resolution more difficult than for African-American adolescents. Comparing place-based influences on psychosocial development offers an important perspective for the practitioner, since much of the research on psychosocial development is based in a few countries and may not be applicable to others.

Chronic childhood poverty can create life-long problems for adolescents. This is particularly true for those who have experiences with poverty in early childhood. This article will examine how risk and protective factors influence the effects of chronic poverty on adolescent development. Unfortunately, research on risk and protective factors and psychosocial development has been undertaken primarily in the United States and Europe, making the applicability of findings questionable for other parts of the world. This study will also compare conditions of chronic poverty and adolescent development in the United States with those in South Africa, exploring place-based influences on the psychosocial development of American and South African Black adolescents.

THE EFFECTS OF CHRONIC POVERTY

There is less knowledge of the effects of chronic poverty on adolescents than on children in general (Garbarino, 1985), but there is some consensus concerning the long-term effects of chronic poverty on child well-being, and these

insights can be applied to adolescents.[1] Jeanne Brooks-Gunn (1995) defines child well-being as social, cognitive or academic, mental or emotional, and physical health and development. The measures of child well-being should also be applied to adolescents. Each of these measures can be influenced by the depth, timing, and duration of poverty.

Cognitive Capacities

Young children who are chronically poor have deficits in verbal memory, vocabulary, math and reading achievement, and may exhibit problem behavior (Brooks-Gunn, 1995; Korenman, Miller, and Sjaastad, 1994). These deficits are not accounted for by family structure, maternal education, academic ability or deficiency, but by the depth of poverty, and are substantially worse among the chronically poor than among children who were poor for 1 year or less (Korenman et al., 1994). Family income during the early years of a child's life is significantly related to cognitive and academic development in middle childhood, and is a major indicator of school completion (Balter and Tamis-LeMonda, 1999). Because of this, family income has clear relevance to well-being in adolescence and the development toward adulthood.

Psychological Well-being

Although poverty in adolescence has less influence on grades than poverty in earlier childhood, adolescent poverty does predict delinquency, depression, and loneliness (Balter and Tamis-LeMonda, 1999). According to Laurence Balter and Catherine Tamis-LeMonda, male and female adolescents respond differently to poverty and economic hardship. Female adolescents may experience low psychological well-being, while male adolescents may exhibit antisocial behavior. Among the chronically poor, the effects of poverty on early childhood development may combine with the effects of poverty on adolescence, producing potentially harmful results.

Risk Factors

Risk factors generally refer to internal or environmental factors that increase the risk of negative behavioral, physical, emotional, and cognitive outcomes for an individual. Risk factors can significantly exacerbate the detrimental effects of chronic poverty on adolescent development. The negative effect of these risk factors deepens with the intensity and number of risk factors involved (Kemp,

Whittaker, and Tracy, 1997; Eamon, 2001).

In combination, stressors such as early trauma and poor environmental factors are correlated with later life problems (Kemp et al., 1997). For example, chronically low family income levels, compounded by physical health problems and a lack of neighborhood health resources, can lead to increased family stressors (Brooks-Gunn, 1995) and increased effects upon socioemotional development (Eamon, 2001). Among the families and adolescents who continually endure multiple risk factors associated with poverty, the vulnerability is clear (Kemp, Whittaker, and Tracy, 1997).

Living in a dangerous or disadvantaged neighborhood is one such risk factor that deepens the effect of poverty on adolescent development. Because neighborhood quality is associated with effective parenting, school success, health outcomes, and quality of life in general (Kemp et al., 1997), the effects of long-term poverty could be increased by living in a poor, violent neighborhood without the benefits, such as strong, positive social networks and good schools, found in healthier communities.

For adolescents, poverty in earlier childhood would be a significant risk factor. According to Brooks-Gunn, "Once a child embarks upon the path of poor cognitive development or high behavioral problems, in part due to poverty related to circumstances during the first years of life, this trajectory is likely to continue through adolescence and young adulthood" (1995, p. 94). Earlier experiences in poverty are likely to be risk factors, indicating that the length of time in poverty is in itself a risk factor.

In Glen Elder's study on children of the Great Depression, the negative impacts of economic loss on child behavior are largely attributed to increasingly harsh, arbitrary discipline on the part of the father, and this paternal behavior is thought to be due to changes in family income (as cited by Brooks-Gunn, 1995). Because sudden income loss is more stressful than deprivation, sudden income loss could be considered a risk factor (Eamon, 2001). The stresses of negotiating new feelings and freedoms can be significant in the process of adolescent development. Among chronically poor adolescents, the stressors associated with normal adolescent development, combined with poverty-related stressors, could lead to the loss of coping behaviors.

Protective Factors

Fortunately, a number of protective factors can give adolescents coping tools with which to combat the negative effects of chronic poverty. Protective factors are internal or environmental factors that protect an individual from the

negative behavioral, physical, emotional, or cognitive outcomes. The Home Observation for Measure of the Environment (HOME) test shows that the home environment can be a key mediator in the effects of long term poverty (Korenman et al., 1994). The HOME test includes measures of maternal affection, physical aspects of the home, and learning opportunities outside of the home (Korenman et al., 1994). The test can give great insight to the risk and protective factors found in the home (Korenman et al., 1994; Balter and Tamis-LeMonda, 1999). Although it is not clear which of the variables measured in the HOME test are most significant (Korenman et al., 1994), strong social networks and social support for the parents seem to buffer the stressors associated with poverty in family life by contributing to more positive interactions between family members (Balter and Tamis-LeMonda, 1999). It may be expected that without such social supports as family, community, and friends to give parents respite from child care or to offer financial or emotional support, the cumulative effect of difficult family interactions and chronic poverty-related stresses could be too much for many families to handle.

Susan Kemp, James Whittaker, and Elizabeth Tracy (1997) do an excellent job of summarizing several resiliency factors. As used by Kemp, Whittaker, and Tracy (1997), resiliency factors include personal, familial, and community protective factors. These contribute to positive outcomes for children, in spite of the hardship that they encounter, and are clearly applicable to adolescents, as well as younger children. Personal resiliency factors include cognitive competence, action orientation, and active coping. All of these could be reduced by serious deprivation. Fortunately, there are several other personal factors, such as easygoing temperament, hope, experiences in self-efficacy, realistic expectations and appraisal of the environment, empathy, and adaptive distancing. There are also many familial and environmental resiliency factors. Because these personal factors are either rooted in personality or, in the case of most of those mentioned, are actually further developed by challenges in one's personal life, there is hope for chronically poor adolescents. Family and environmental resiliency factors include stable, positive relationships with adults, positive parental modeling of coping skills, support networks, realistically high expectations (in school and community), consistent social support, positive community norms and role models, and community resources for families, as well as for adolescents (Kemp et al., 1997).

CHRONIC POVERTY AND AMERICAN ADOLESCENTS

In the United States, 13.9 percent of children live below the poverty line, and the poorest fifth of all children are poor for much longer than in any other

major industrialized nation (United Nations Children's Fund [UNICEF], 2000). In fact, this poorest fifth of children in the United States are less likely to move out of their income bracket than counterparts in any other industrialized nation (United Nations Children's Fund, 2000). Six percent remain poor for 10 years or longer (United Nations Children's Fund, 2000). In comparing long-term poor children with those who have been poor for only 1 year, development indicators show that long-term poor children have various and substantial deficits. Also noteworthy is the fact that family income in a child's younger years is a better predictor of school completion and cognitive development measures than income in adolescence. These observations give some sense that chronically poor adolescents can be affected by the length of their poverty in ways that newly poor adolescents cannot (Korenman et al., 1994; Balter and Tamis-LeMonda, 1999). Adolescents must negotiate new roles as they transition into adulthood. Without the strong presence of protective factors, economic hardship and the denigration that comes of being poor in America's bootstrap culture could make the developmental tasks of adolescence overwhelming.

CHRONIC POVERTY IN SOUTH AFRICA

Very few studies have been undertaken to examine the effects of chronic poverty on adolescents. It is therefore necessary to piece together that information from what we know about children and chronic poverty. The situation is no different in the available South African research. One excellent study on South African children illustrates in great detail the situation of thousands of children born on the dawn of Nelson Mandela's release from prison. Titled *Mandela's Children*, the book is based on a longitudinal cohort study and gives insight into the conditions faced by the millions of South African children now coming into adolescence. The authors consider chronic, multigenerational poverty to be a massive threat to the Black youth of South Africa (Barbarin and Richter, 2001).

Comprising 44.24 percent of the population, children and youth under 18 are particularly affected by poverty. Six out of 10 children are poor in South Africa. By comparison, this is true for a little more than 1 out of 10 children in the United States (Robinson and Sadan, 1999; UNICEF, 2001).

Access to basic infrastructure is a major problem in South Africa. Shirley Robinson and Mastoera Sadan report that in 1996, only 44.7 percent of the nation had access to potable, municipal water sources. Sanitation services were available to only 50.3 percent of South Africa's population, and 52.2 percent

of the nation had access to refuse services (Robinson and Sadan, 1999). The lack of potable water sources and refuse and sanitation services creates health risks for a large percentage of the population.

With these figures, it is no surprise that chronic poverty is deadly in South Africa. Twelve out of every 100 South African children die before the age of 5. One-quarter of South African children are stunted from long-term malnutrition. Although stunting is prevalent among Black children, the effect of long-term malnutrition is by no means limited to them. Chronic, inadequate nutrition is a problem in at least three major racial segments of South African society (Barbarin and Richter, 2001). Among colored and Indian children (South African racial distinctions constructed under apartheid), one-third of children under 14 are underweight and stunted (Barbarin and Richter, 2001).

SUITABILITY FOR COMPARISON

Comparing the experiences of South African Black adolescents with American Black adolescents allows practitioners to understand differences between psychosocial development in a country in which research is limited and that in one where seminal research has been done. Examining race and place-based differences also assists practitioners in applying theory appropriately without assuming similarities or differences from the theorists' original sample.

In examining the differences between chronically poor Black adolescents in the United States and chronically poor Black South African adolescents, several key issues arise. One is the extent to which the experiences of each group are comparable. This issue is dealt with by Oscar Barbarin and Linda Richter's detailed study (2001) on Mandela's children. Much of the South African literature concerning poverty and child development is based on studies of American children. They find numerous similarities between families in South Africa and the United States, and test several measures used in American studies, finding them fairly helpful when slightly modified to address the differences in African and American culture (2001).

Because South Africa and the United States are both nations in which racial segregation and Black migration have played major political, cultural, and individual roles, these two countries may be particularly suitable for comparison, despite differences in the countries themselves and the timeline of such events. Furthermore, since chronic poverty is particularly prevalent among Blacks in both countries, our discussion will now focus on the similarities and differences in psychosocial development among Black Americans and

Black South Africans (Barbarin and Richter, 2001; Blank, 1997).

CHALLENGES TO PSYCHOSOCIAL ADOLESCENT DEVELOPMENT

According to James Marcia, as adolescents develop, seven psychosocial issues arise concerning identity conflict (Sadhna Diwan, personal communication, October 20, 2003). These require resolution. The current study will focus on four such issues: self-certainty versus self-consciousness, role experimentation versus role fixation, apprenticeship versus work paralysis, and leadership or followership versus confusion of values.

Melvin Lewis and Fred Volkmar (1990) consider the consolidation and integration of one's personality, as well as adaptation to the changing, unfamiliar society, to be two of the pivotal developmental tasks of adolescence. Because Black youths in both countries must find their identity in societies that often hold clearly negative stereotypes of Blacks, these tasks become even more difficult.

For all youths, physical growth in infancy and childhood set the stage for biological, behavioral, and emotional self-regulation. According to Barbarin and Richter, biological, behavioral, and emotional self-regulation are the foundations for many things, including social competence and psychosocial maturity in adolescence (2001). They argue that many of Mandela's children struggle with behavioral and emotional self-regulation. For South African adolescents, the prevalence of stunting is also directly connected to success in adolescence; for African-American youths, social programs like Food Stamps and Temporary Aid for Needy Families (previously known as Aid to Families with Dependent Children) have reduced the likelihood of severe physical side effects of chronic poverty but not its psychological effects (Barbarin and Richter, 2001; Blank, 1997).

For adolescents in South Africa, a rapidly changing social milieu, racial discrimination, neighborhood violence, and large numbers of deaths due to sickness and malnutrition present stresses. These pose constant threats to personal equilibrium and positive resolution of identity conflict (Newman and Newman, 2003). For African-American adolescents, the physical effects of poverty are generally less severe, suggesting that neighborhood violence and racial discrimination are two core threats to identity development (Barbarin and Richter, 2001; Blank, 1997). Being chronically poor becomes a more serious threat to healthy adolescent development when familial support and coping behaviors are absent or seriously deficient. Unfortunately, chronic

poverty and deprivation break down the coping behaviors needed to successfully develop a positive self-identity in an environment of denigrated or violent role models and palpable racial discrimination (Eamon, 2001).

The Changing Social Milieu

While the political and social environment has not changed significantly for African Americans in the past 10 years, it has certainly changed in that time for Black South Africans. In 1990, Nelson Mandela was freed and apartheid subsequently came to an end. In many ways, South Africa is going through changes experienced in the United States during the 1940s, 1950s, and 1960s, with a significant change from rural to urban society, Black migration to the cities, and the end to segregation, the American equivalent of apartheid (Patterson, 2000).

Unfortunately, thousands of Black families who left the South African countryside for the promised employment and education of the city face inadequate shelter and dangerous environmental conditions as they cope with the massive changes in family and community life that have left many families isolated (Barbarin and Richter, 2001). In South Africa, the movement of Black families to crowded urban shantytowns and blighted business districts has separated these families from extended kin networks that formerly provided much-needed support through familial systems of mutual obligations (Barbarin and Richter, 2001). For developing teens in the United States, urban migration happened two generations ago. New kinship networks have since grown to assist young people in negotiating role and work identity, and authority development. Many Black South African teens no longer have access to the support network or to the traditional practices and rituals that gave order to their parents' or grandparents' transitions from childhood to adulthood (Barbarin and Richter, 2001).

Household Make-up

One of the key problems facing Black adolescents in South Africa is the massive scope of changes in household make-up. Although the rate of single motherhood has risen in the United States, irrespective of race, it is a particular and growing problem among South African Blacks (Blank, 1997; Barbarin and Richter, 2001). With desperate, chronic poverty and relocations to cities, parents have to live separately in order to support the family (Barbarin and Richter, 2001). South African Black households typically contain significantly more children than American Black households. South

Africans have a Gross National Income of $2,900 in U.S. dollars, and much fewer supportive services available. It is arguable that South African mothers, fathers, and other caretakers are more taxed, with significantly smaller resources at their disposal (Barbarin and Richter, 2001; United Nations Children's Fund, 1999).

In South Africa, Barbarin and Richter (2001) report that one child in three under the age of 16 does not live with his or her mother, and that one in five lives with neither parent (Barbarin and Richter, 2001). Because AIDS is expected to infect one in four adults in southern Africa within this decade, it is unlikely that these children will return to live with their parents soon (Barbarin and Richter, 2001). For adolescents, all of these factors mean less time with a caring, committed caretaker, leaving them more vulnerable to the negative effects of chronic poverty. Without a caring adult in the home as a supportive role model, adolescents may have serious trouble with positively resolving issues of role experimentation and leadership and followership. They may also have difficulty developing healthy self-certainty.

Neighborhood Violence

A surprising similarity between South African and American Black experiences lies in the prevalence of neighborhood violence. In the Barbarin and Richter's study (2001), South African parents reported neighborhood safety in similar percentages to those reported by American parents. Only 22 percent of Black South African parents considered their neighborhood safe. According to Barbarin and Richter (2001), this is comparable to the experience reported by African-American parents. In both countries, rising gang activity and juvenile crime are primary concerns, suggesting that violence in neighborhoods is a key concern (Barbarin and Richter, 2001).

It can be argued that chronic poverty and racial discrimination can combine to cause negative resolution in conflicts between role experimentation and fixation, apprenticeship and work paralysis, and leadership and authority confusion. Delinquency and gang membership can result if one or more of these conflicts is not resolved but instead leads to confusion. For the majority of both South African and African-American youths, chronic poverty and racial bias limit their neighborhood choices, relegating them to neighborhoods where violence is a regular part of life (Barbarin and Richter, 2001). Regular exposure to crime and the standardization of antisocial behavior provides negative roles for experimentation and the possibility for authority confusion or negative resolution of followership issues. This occurs when those who rule the block are made powerful through violence and coercion (Barbarin and

Richter, 2001).

Continued exposure to neighborhood, community, and possibly familial violence, through the medium of chronic economic hardship, may increase an adolescent's proclivity to engage in antisocial behavior, such as aggression and delinquency. Such exposure may also lead to underemployment, which suggests evidence of work paralysis (Barbarin and Richter, 2001). Engagement in aggression and delinquency may make it more difficult to achieve academic success. Academic failure is already a risk for chronically poor youths, leading to extended difficulty in engaging in meaningful, well-paying work (Barbarin and Richter, 2001; Brooks-Gunn, 1995; Korenman et al., 1994). An adolescent faced with the decision between working legally for a pittance and engaging in the informal economy for substantially larger, though illicit, wages may experience long-term work paralysis in the form of such illegal activities as drug dealing.

The Loss of Adolescence

In many ways, African-American youths have the luxury of a longer adolescence than do many Black South African teens. Although adolescents from poorer American families generally start work earlier and have a shorter adolescence than do wealthier adolescents, South African adolescents are faced with a myriad of challenges that shorten their adolescent experiences even further (Lewis and Volkmar, 1990). The extent of AIDS infection in Southern Africa, the deeper level of poverty in South Africa, and an unreliable national infrastructure can combine to hurry or halt the development process for adolescents.

The confluence of economic hardship and the accumulation of risk factors is known to increase premature sexuality and childbearing (Barbarin and Richter, 2001). Orphaned South African adolescents learn at a young age to provide for siblings in the absence of a parent. If they engage in immature sexual behavior, these adolescents may easily find themselves infected with HIV or giving birth to an HIV-infected baby (Barbarin and Richter, 2001). Adolescents who suddenly find themselves supporting others through the death or illness of a caretaker or through the birth of their own child may not have the luxury of engaging in role experimentation, but may experience identity foreclosure. In identity foreclosure, very little role experimentation occurs (Newman and Newman, 2003). These adolescents may also experience identity moratorium, in which the subject's role or identity is put on hold (Newman and Newman, 2003). African-American youths may also experience

identity foreclosure and moratorium through early work or pregnancy, but a more supportive infrastructure in the United States ensures that American adolescents will have a somewhat better chance of receiving a decent education and attending university, a key place for role exploration. Because South African teens are more likely to lose one or both parents through death and may already be separated from kinship networks, many may lose the very important protective factor embodied in a caring, engaged, adult caretaker (Barbarin and Richter, 2001).

Denigration of the Self

Adolescents who are unable to achieve positive identity resolution may experience the perpetuation of self-denigration. Because group identity is such a pivotal developmental task for adolescents, personal identity is often tied to connection with a group. As Barbara Newman and Philip Newman aptly write, "Perceiving oneself as a competent member of a group or groups is fundamental to one's self-concept as well as one's willingness to participate in and contribute to society" (2003, p. 318). For chronically poor Blacks in South Africa and the United States, the natural progression of group identification can easily lead to self-denigration. As Lillian Rubin (1992) finds, children of even the working poor are exposed to denigration of their parents by the larger society. Among those whose poverty is compounded by racial denigration and the scorn reserved for those who are perceived as choosing not to work, the denigration of the self is an easy step. In Barbarin and Richter's study (2001), a primary wage earner with low-prestige work is clearly associated with aggressive behavior among children in Black South African households. This pattern of response to parental status often continues in adolescence (Barbarin and Richter, 2001). Thus, the outgrowth of familial denigration can be the adolescent's negative personal identity resolution, authority confusion, or role confusion. Compounded with a group identity linked to a poor, violent neighborhood, and denigrated by the outside world, self denigration can easily occur.

An important difference between South African and American Blacks lies in the fact that American Blacks are part of the minority. South African Blacks not only comprise the majority in their country, but they are organized into strong ethnic groups, clans, and family associations. These associations share languages and traditions as their common connection. These ancient affiliations are noticeably absent from the African-American experience. However, while the majority status may foster a sense of strength and a strong connection to a rich group history for South African Black adolescents, these adoles-

cents still experience the difficulties that Ronald Takaki describes as looking in a mirror and seeing nothing (1993). Although they form a numerical majority, South African Blacks, like African-Americans, live in a culture where faces like theirs are rarely seen in positions of political power. While this has changed for the better in the past decade, much progress must still be made before Black adolescents in either country will have significant numbers of highly visible, positive Black role models needed to diminish self-denigration.

CONCLUSION

The difficulties in psychosocial development among chronically poor South African adolescents are exacerbated by cultural upheaval and the AIDS crisis. Destitute conditions in South Africa may make identity development more difficult there for chronically poor adolescents than for Black adolescents in the United States. While adolescents in the United States have the strength of a more developed infrastructure and social welfare system, key strengths for South African adolescent psychosocial development include strong connections to a rich group history and the underlying power that comes with membership in a majority group. ■

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NOTE

1. The term "chronic poverty" is rarely defined. For the purposes of this article, chronic poverty will be considered poverty that reoccurs or extends over several years or several generations, and that may threaten the individual's basic existence (Brooks-Gunn, 1995; Blank, 1997).

ABOUT THE AUTHOR

MEEGAN BASSETT is an Iowa native currently studying for her master's degree in social work with a concentration in social administration. She holds bachelor of arts degrees from North Park University in sociology and Spanish, *cum laude*. Meegan's research interests include workforce development, work cooperatives in Latin America and Africa, resource distribution, and skills training.

Socioeconomic Status and the Treatment of Depression: The Role of Therapist Attitudes, the Therapeutic Relationship, and Addressing Stressful Life Circumstances

By Lydia Ann Falconnier

Submitted December 2003 to the faculty of the University of Chicago School of Social Service Administration

CHAIR: Irene Elkin, Ph.D.

This study examines outcomes and attrition across three treatments for depression in relation to socioeconomic status (SES). It also evaluates the role of therapist attitudes and the therapeutic relationship as mediators of the relationship among SES and attrition and outcome. Finally, the study explores how therapist responses to in-session material related to financial, work, and unemployment stressors are related to both process and outcome variables.

This study is based on data and videotapes available from the Treatment of Depression Collaborative Research Program (TDCRP) of the National Institute of Mental Health. The TDCRP is a multisite collaborative study that examines the effectiveness of psychotherapy and pharmacotherapy for the treatment of depression. The current study is in two parts. The first part, the predictive study, consists of secondary analysis of data already collected for the TDCRP. The second part is a process study of a subsample of the outcome study patients, including lower SES patients and a comparison group of higher SES patients. In the process study, videotaped treatment sessions are used to explore therapists' approach or avoidance of in-session material related to stressful life conditions.

Predictive study results indicate that lower SES is associated with less improvement across all three treatments for depression. SES is not associated with attrition. Therapist attitudes, but not the therapeutic relationship, medi-

ated the SES-outcome relationship. The process study results show that higher levels of therapists' approach of financial, work, and unemployment topics are associated with greater improvement across socioeconomic status groups.

The most important implication of the current findings for clinical practice is that clinicians must be aware that there may be limitations in the use of these empirically validated treatments with lower SES depressed patients, as their improvement rates are likely to be less than those of middle SES depressed patients treated by the same modalities. Social workers using these modalities with lower SES patients should consider modifying them to include elements discussed in several theoretical, clinical, and empirical sources.

A second finding highlights the importance of addressing economic stress in the treatment process. The findings suggest that clinicians should inquire about and encourage discussion of economic stressors in the early sessions of treatment for both lower and middle SES patients.

Finally, this study documents the role played by therapist attitudes in influencing differential improvement by SES in therapy for depression. It is important for therapists to be aware of their own stereotypes about motivation and prognosis for lower SES patients. It also suggests that clinician training include education about the difficult life circumstances faced by lower SES patients. ■

ABOUT THE AUTHOR

LYDIA FALCONNIER graduated from the Ph.D. program at the School of Social Service Administration in December 2003. Her dissertation research evaluated the relationship between socioeconomic status and both the processes and outcomes of treatment for depression. In August 2002, she accepted a position at the University of Illinois at Chicago, where she is currently an assistant professor at the Jane Addams College of Social Work. Her research interest in poverty and mental health continues, with a current focus on interventions for mentally ill parents whose children are in the custody of the Illinois Department of Children and Family Services.

Advancing in One's Calling: The Roles of Internal Labor Markets and Social Capital in Human Services Career Plateauing

By Anna Haley-Lock

Submitted December 2003 to the faculty of the University of Chicago School of Social Service Administration

CHAIR: Susan Lambert, Ph.D.

This project is designed to expand our current theoretical and practical understandings of the ways workplace opportunity is provided and accessed within a population of small human service organizations. It draws on the literatures of internal labor markets (ILMs) and social capital to illuminate important but underattended explanations for employee advancement in these settings. The study also conceptualizes advancement to include not just the traditional form of upward mobility but also salary growth, as well as workers' perceptions of both.

I targeted for data collection the population of 25 nonprofit social service organizations in the Chicago metropolitan area dedicated to providing domestic violence intervention programming, and the universe of their workers. Of these, 21 agencies and 477 workers (68 percent of 697) participated. I used two instruments to gather organizational and individual-level information between December 2000 and June 2001: a structured interview protocol for administrators and a self-administered worker survey. I analyze these multilevel data using Hierarchical Linear Modeling.

I find that opportunities for promotion, skill development, and working full-time are not distributed evenly, but instead vary both between positions within the same agency and between agencies. Access to these workplace benefits, therefore, seems to be a matter of obtaining the "right" job in the "right" organization. In addition, the provision and receipt of these ILM rewards are often found to play a significant role in the extent to which workers progress

hierarchically and in compensation. The findings also suggest, however, that ILM-based opportunities are not always positively associated with workers' real or perceived advancement. Rather, in several instances, their availability was linked to disproportionately poorer worker outcomes.

Results also reveal that having weak ties and large networks, as previous network analytical studies find, both are positively related to workers' upward mobility prospects. Contrary to expectations, however, network diversity through contacts spanning beyond the workplace is negatively associated with other forms of advancement. These findings together suggest that in nonprofit human services contexts, ILMs and networks may appear, and also function, differently than previously studied workplaces in facilitating workers' growth in their jobs. ■

ABOUT THE AUTHOR

ANNA HALEY-LOCK received her M.A. from the School of Social Service Administration in 1995 and her Ph.D. from the School in 2003. She also served as a research associate and part-time lecturer. She is currently an assistant professor at the University of Washington School of Social Work and teaches and conducts research in the area of organizations and administration. She is particularly interested in contributing to theoretical and practical understandings of how organizational structures—through the design of workplaces and jobs—facilitate or limit individuals' abilities to advance personally and professionally, as well as how structures balance the demands of work and nonwork spheres.

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