

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

SSA/CHICAGO

Advocates' FORUM

10TH ANNIVERSARY ISSUE



2005

Advocates'
FORUM

2005

COEDITORS IN CHIEF

Alexis Jaeger
Charlotte Hamilton

EDITORIAL BOARD

Meegan M.D. Bassett
Stephen Brehm
Marianne Cook
Charlotte L. Hamilton
Matthew Hayden
Alexis Jaeger
Christina James
Rebecca Kuhlmann Taylor
Andréa Taylor
Aaron Willis

ADVISOR

Virginia Parks, Ph.D.

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 contribute 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 (SSA) 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:

Advocates' Forum
School of Social Service Administration
The University of Chicago
969 East 60th Street
Chicago, IL 60637

WEB ADDRESS

<http://www.ssa.uchicago.edu/publications/advoforum.shtml>

ESSAYS AND ARTICLES

Advocates' Forum — Ten Years of Advocacy for the Social Work Profession
by *Stephen Brehm* 6

Health Care Reform: Strategies and Successes of the Campaign for Better Health Care
by *Andréa Taylor* 9

Literature Search and Application: Interventions for Children with Insulin-dependent Diabetes Mellitus
by *Bridget M. Colacchio* 20

Anti-Drug Legislation and the Rising Incarceration of Women: Recommendations for Future Sentencing Reform
by *Charlotte L. Hamilton* 33

Gay and Lesbian Adolescent Psychosocial Development in Urban and Rural Settings
by *Frank Baiocchi* 44

Child and Adolescent Refugees: Developmental Differences
by *Amanda Posner* 54

Homeownership as an Urban Development Tool
by *Nicole Hrycyk* 64

DISSERTATION ABSTRACT

Substance Abuse Treatment: An Organizational Perspective
by *Melissa Walker* 82

ON THE COVER

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

FROM THE EDITORS

This year, the *Advocates' Forum* celebrates its tenth anniversary. The journal has had several incarnations over the years, yet it continues to be the premier social work student journal in the nation. The School of Social Service Administration offers its students the rare opportunity to express themselves in the academic forum provided by this publication. Contributors present informed opinions, based in academic analysis and research, that speak to relevant social issues. Over the past decade, the journal has allowed students at the University of Chicago to make a respected contribution to professional knowledge in the field of social work.

In commemoration of those who have contributed to *Advocates' Forum* in the past, as well as of those who will carry it into the future, we have included a brief history of the journal, written and researched by Stephen Brehm. This piece presents the perspectives of the journal's many editors, beginning with our founder, and describes *Advocates' Forum's* evolution throughout the years. The knowledge and insight provided by this reflection remind us of the spirit in which the journal was created, and will help guide *Advocates' Forum* into another 10 years of creativity and collaboration.

We are pleased to present the eleventh volume of *Advocates' Forum*. The articles were selected through our professional peer-review process and maintain high academic standards. While the volume captures the diverse interests of the student body, each author demonstrates a commitment to social work values. Andréa Taylor provides us with an insightful analysis of organizing efforts for health care reform. Bridget Colacchio contributes a literature search with compelling clinical implications for children with diabetes. In her piece, Charlotte Hamilton advocates for legislative reform of anti-drug laws in connection with the rising incarceration rates of women. Frank Baiocchi offers a clinical evaluation of gay and lesbian adolescent development in both urban and rural settings. Amanda Posner's article evaluates the developmental differences found in child and adolescent refugees.

Finally, Nicole Hrycyk presents an analysis of homeownership initiatives as tools for urban development.

In creating the tenth anniversary volume of *Advocates' Forum*, our hope is to provide you, our readers, with a body of work that captures the legacy of the journal and makes an enduring contribution to academic discourse within the social work profession.

Alexis Jaeger
Charlotte L. Hamilton

COEDITORS 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, our brilliant and dedicated copy editor, for all their efforts and invaluable input in creating this year's volume. We would also like to thank Paulette Yousefzadeh for her counsel. We could not have done it without you all.

ABOUT THE EDITORIAL BOARD

MEEGAN M.D. BASSETT is an Iowa native currently studying for her master's degree in social work with a concentration in social administration. She holds a Bachelor of Arts degree 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.

STEPHEN BREHM is a first-year clinical student at the School of Social Service Administration, specializing in school social work. He graduated from Barat College with a B.A. in psychology. Stephen also holds a master's in information systems management that he acquired while working as a project manager at a statistical software company, prior to attending SSA. Stephen is currently an intern at El Cuarto Año alternative high school and a research assistant for the Institute of Mind and Biology. Stephen hopes to do research and to work with elementary school students, emotionally disturbed children, and families. His social work interests include childhood mental disorders, statistical research methods, and technology for social service providers.

MARIANNE COOK is a first-year clinical student at the School of Social Service Administration. She graduated from Harvard University with a bachelor's degree in psychology. Prior to attending SSA, she worked in the Middle East and in Southeast Asia. She is interested in counseling programs for children and adolescents, and plans to concentrate in school social work.

CHARLOTTE L. HAMILTON is a first-year clinical student at the School of Social Service Administration. She received her B.A. in English from Wellesley College in 2001. She is currently working with older adults at Villa Guadalupe Senior Services. Her areas of interest include women's issues, mental health, and incarceration.

MATTHEW HAYDEN is a second-year clinical student at the School of Social Service Administration, where he is president of the Student Government Association. 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. He is currently an intern in the Department of Psychiatry at the University of Chicago Hospitals. Previous work experiences include refugee services, women's reproductive health care, rape-crisis services, youth work, teaching, higher education administration, and music performance. He hopes to work in mental health counseling upon graduation.

ALEXIS JAEGER is a second-year clinical student at the School of Social Service Administration. Prior to attending SSA, she worked as a community organizer with subsidized housing tenants in New York City. She graduated from the University of Wisconsin-Madison with a B.A. in English. Alexis is currently an intern at Inspiration Café, where she provides counseling and case management to homeless adults. Her social work interests include affordable housing, homelessness, and community mental health.

CHRISTINA JAMES is a first-year clinical student at the School of Social Service Administration. Prior to coming to SSA, she worked for a nonprofit organization serving low-income children and families in New Orleans, LA, and for the U.S. Department of Justice. Christina would like to continue her work with low-income children and families, with a focus on family support and child and family policy. Christina graduated from Tufts University with a B.A. in English and a minor in sociology.

REBECCA KUHLMANN TAYLOR is a second-year student at the School of Social Service Administration. Prior to attending SSA, she directed a family literacy program at Jane Addams Hull House Association and served as an administrator at Cornerstone Counseling Center of Chicago. She graduated *magna cum laude* from Wheaton College, earning a bachelor's degree in sociology. Rebecca currently works as a Program Intern at The Field Foundation of Illinois and as the Youth Director at LaSalle Street Church. She is a Presidential Management Fellowship finalist and is pursuing a career in public service, nonprofit management, or program evaluation.

ANDRÉA TAYLOR is a second-year administration student at the School of Social Service Administration and is also in the Graduate Program for Health Administration and Policy. She is a graduate of Wheaton College with a B.A. in anthropology and English literature. Andréa's social work interests are health policy, immigration issues, and international development.

AARON WILLIS is a first-year clinical student at the School of Social Service Administration. Aaron is interested in evidence-based practice for substance abuse treatment and child welfare. Prior to attending SSA, Aaron lived in St. Paul, MN, worked as a child protection worker, and volunteered as a board member for the Tourette Syndrome Association of Minnesota. Before his child welfare experience, he worked with a diversion program for juvenile offenders and provided mediation services for the victims and offenders. Aaron received a B.A. in religion and criminal justice from Gustavus Adolphus College.

ADVOCATES' FORUM — TEN YEARS OF ADVOCACY FOR THE SOCIAL WORK PROFESSION

Prepared by Stephen Brehm

Advocates' Forum represents the School of Social Service Administration's first publication initiated, written, and managed entirely by students. Celebrating its 10 year anniversary with this year's publication, *Advocates' Forum* was first published in December of 1994 and edited by founder Valerie Leon (A.M. 1995). As Ms. Leon noted in that issue's "Letter from the Editor," this publication was "the product of six months of planning and discussion begun by a small group of second year SSA students." The founder's goal was to "provide a forum for students and alumni to share ideas and information relevant to the field." Valerie recently reflected on her inspirations for starting *Advocates' Forum*:

While I was at SSA, I was amazed at all of the intelligent, passionate people I was meeting. I had a part-time job working in the Office of External Affairs for a man named Gary Grant. Jeanne Marsh was the dean then. Gary and I used to talk about the variety of students I was meeting, the different worldviews and areas of interest. Yet we were all so busy with our coursework and fieldwork that we barely had the opportunity to discuss the issues that were most important to us. In 1994, I told him I would like to start a publication that would provide an opportunity for debate and discussion. I could see that all SSA students were not on the same page. Some were liberal, some conservative.... So, I conceived of the idea of a newsletter (not yet the journal that it has become) and we set to work. First I advertised for interested students and put together a board. These people served as a sort of sounding board for me and also made submissions to the publication. In effect, we generated the material for the *Advocates' Forum*. Gary [Grant] and I brainstormed for a while and came up

with the title, which I still love! We selected the articles based on word of mouth. If I heard someone in class talking about their field placement and it sounded interesting, I would ask them for an interview. (Interview with Valerie Leon-Criminger, 2005)

In regard to the evolution of *Advocates' Forum* since its inception, Valerie commented:

I'm not sure how the focus has changed over the years, but my impression is that it has become much more academic. In some ways, I am impressed. But I'm not sure the *Advocates' Forum* is serving the same function that I intended. I like the intellectual exchange of ideas and it certainly fits with the overall flavor of the university. But I think it is important for the school to have a forum for students to grapple honestly with the difficult issues we face as social workers. (Interview with Valerie Leon-Criminger, 2005)

Valerie's thoughts echo the spirit with which she started the publication.

Since the journal's inception, 18 issues have been published. The first 6 years saw three issues per year, each devoted to a specific social problem, such as early intervention, welfare reform, adolescents, and identity. In more recent years, the journal has been published once a year and more broadly "explores clinical implications, social issues, administration, and public policies linked to the social work profession" (from *Advocates' Forum* Mission Statement).

In *Advocates' Forum*'s second year of publication, coeditors Eric Lock (A.M. 1996) and Ann Maxwell (A.M. 1996) published three issues, each publication focusing on a specific theme. Eric Lock edited the December 1995, March 1996, and May 1996 issues. Reflecting on why he got involved, he said that his reasons aligned well with the journal's founding mission. He said he was inspired by Valerie Leon's "motivating impulse" to create a "sounding board" that would "stimulate more dialogue about the profession." In addition to the founding efforts of Valerie, the first editorial board, and the journal's first faculty advisor, Eric credits Gary Grant (former SSA Associate Dean of External Affairs) with helping to sustain *Advocates' Forum*'s momentum and making it the well-received journal it is today. Eric believed the journal was more than a forum to discuss social issues of relevance to social work students and professionals; he saw it also as a tool that "helps like-minded people to find each other" (Interview with Eric Lock, 2005).

Advocates' Forum continues to provide a channel through which students can make scholarly contributions to the social work profession. Starting in the

2004 issue, the journal became a forum in which Ph.D. candidates can publish their dissertation abstracts. The 2004 issue was also the first to institute a peer-review process, further adding to the journal's integrity and professionalism. Paulette Yousefzadeh, coeditor of the 2003-2004 volume, reflected on this development in a recent interview:

I became involved with *Advocates' Forum* because I happen to enjoy the review and editing process that goes along with writing. I was impressed with the direction that the journal was taking at the time that I joined, which was towards a more academic and research emphasis. As an aspiring social work researcher, this evolution, not surprisingly, appealed to me.

At the time that I was on the editorial board, our goal, I would say, was to select papers that would reflect the diversity of the social work profession in terms of populations that are (or need to be) served, intervention types and methods, and so on. We aimed to include papers that serve as examples of clear and logical argumentation based on the evidence from research (Interview with Paulette Yousefzadeh, 2005).

Thanks to dedicated students and a supportive administration, we can look forward to a future of significant and thoughtful contributions to the social work profession. These efforts produce scholarship that captures the spirit of *Advocates' Forum*—an invaluable resource to its readership. ■

HEALTH CARE REFORM: STRATEGIES AND SUCCESSES OF THE CAMPAIGN FOR BETTER HEALTH CARE

By Andréa Taylor

This article explores the strategies and successes of the Campaign for Better Health Care (CBHC), arguing that the CBHC is employing effective organizing strategies to build a strong coalition across many domains, both public and private, in order to increase health care for the poor. By forging improbable relationships among disparate groups, the CBHC successfully addresses many traditional critiques of community organizing efforts. While the legislative goals of the CBHC still face significant challenges, the campaign provides a critical model for community organizing in a modern context.

Community organizing has a long and somewhat convoluted history in the United States. Models of organizing run the gamut, from working with the system and traditional power structures to turning those structures upside down through disruptive practices. A study of history demonstrates that place, time, and goals greatly affect which approach will be most successful for a range of community initiative efforts. This article explores the strategies and successes of a community initiative in Illinois, the Campaign for Better Health Care (CBHC). This evaluation suggests that the CBHC is employing effective organizing strategies to build a strong coalition across many domains, both public and private, in order to increase health care for the poor.

THE HEALTH CARE CRISIS

Health care and the growing number of uninsured people in the U.S. have been hot topics in election campaigns over the last few years (Commission on Presidential Debates, 2004). The increasing attention on growing rates of uninsured people is due to many factors, including the shifting economy, the

2004 presidential election, and the efforts of community organizers. But how serious is the problem?

According to study by Families USA, about a third of people living in Illinois (3.5 million) were without health insurance for all or part of 2002-2003 (Families USA, 2004). The U.S. Census Bureau reports that half of this population, 15 percent of Illinois residents, had no health insurance at any point during that time (DeNavas-Walt, Proctor, and Mills, 2004).¹ Not surprisingly, low-income families in Illinois are much more likely to be uninsured than their higher-income neighbors: almost 60 percent of Illinois families with incomes at or below 200 percent of the federal poverty level are uninsured. By contrast, 20 percent of those with incomes above 200 percent of the poverty level are uninsured (Families USA, 2004).

Important trends have been garnering the attention of Illinois' legislators and community activists recently. One such trend is the steadily increasing number of uninsured residents. According to Families USA, the number of nonelderly Illinoisans without health insurance rose 13 percent (408,000 people) from 2000 to 2004 (CBHC and Families USA, 2004). Another key trend is that minorities are far more likely to be uninsured than white residents. In fact, in Illinois, Hispanics are the most at risk to lack health insurance. Twenty-nine percent of Hispanics are uninsured. Twenty-three percent of black non-Hispanics are uninsured, and 19 percent of other minorities (including multiracial) are uninsured. By comparison, 10.5 percent of whites lack health insurance (Families USA, 2003). Immigrants are also at great risk of having no access to insurance. In Illinois, legal immigrant children are eligible to be covered under KidCare but their parents are not. Even with the state-funded KidCare program, one in 10 Illinois children are not enrolled in any health insurance plan, and this number is higher for immigrant children, both legal and undocumented (CBHC and Families USA, 2004).

Labor trends and shifts in the U.S. economy are also crucial components of the health care problem. Because of rising health insurance premiums and decreasing profit margins, U.S. employers are less likely to offer health coverage than in the past, and even if they do, employees may not be able to afford it. The average amount paid by an employee for health coverage increased by 36 percent between 2000 and 2004, while average wages increased by only 12.4 percent (Families USA, 2003; CBHC and Families USA, 2004). Families with at least one full-time worker make up 51 percent of the uninsured population; families with at least one part-time worker account for another 28 percent (Families USA, 2003). Industries least likely to offer health insurance are also in some of the lowest-paying employment sectors: employees in construction, manufacturing, retail, health care, food services,

and waste management top the list of uninsured workers. In 2003, only a third of low-income Illinoisans received employer-sponsored health plans (CBHC and Families USA, 2004). Additionally, the Illinois economy sustained increased layoffs and a rising unemployment rate over the last 5 years (Illinois Department of Employment Security, 2004*a*, 2004*b*). These events have taken a toll on health coverage; workers are unlikely to be covered by health insurance while between jobs, and many skilled workers have been unemployed for lengthy periods of time as manufacturing jobs continue to move out of the United States.

Legislators at both the national and state levels have been active in health care policy issues over the last decade. There are several safety net programs for low-income Illinoisans, including KidCare and Family Care (Illinois' version of the federal State Children's Health Insurance Program and Medicaid program). Illinois has taken steps to protect small business employees by implementing policy which bars insurance companies from denying small businesses who want to buy insurance plans and from canceling insurance when an employee on the plan gets sick (CBHC and Families USA, 2004). Additionally, the Health Care Justice Act of 2004 (IL Public Act 093-0973) was recently passed by the Illinois General Assembly. It mandates a state-wide review of feasible plans to ensure Illinois residents universal access to health care.

THE CAMPAIGN FOR BETTER HEALTH CARE

Community activists and organizers have long advocated universal health care access for low-income and working-class people. In Illinois, one of the loudest voices in these discussions has been the CBHC, which began as a grassroots coalition and has grown to become an umbrella group with over 300 member organizations. Members of the coalition include community groups, health care providers, labor unions, disability rights organizations, religious communities, and city and state government agencies (CBHC, n.d.).

The CBHC was founded in 1989 with only two staff members. The group's mission statement affirms that the CBHC's stated goal is to "help create and advocate for an accessible, quality health care system that provides for all" (CBHC, n.d.). The organization employs a coalition-building organizing strategy that has assembled a membership of over 300 dues-paying member groups (and about 500 total partners) in the last 15 years. It has forged unlikely alliances among such groups as the Illinois AFL-CIO, UnitedHealthcare, Chicagoland Chamber of Commerce, and Christian, Jewish, and Muslim organizations (CBHC, n.d.). The CBHC coalition

mirrors the famous Back of the Yards Neighborhood Council, organized by Saul Alinsky in the Depression era, in its ability to unite organizations across shared needs. Alinsky (1941) writes of this phenomenon in his own organizational work:

This common immediate stake for church, business, and labor transcended doctrinal differences and has resulted in the development of an unusual understanding between them. It is this unity of purpose, this organized sentiment and opinion that generates an almost irresistible force. (p. 802)

This force of unity and a common identity located in shared concerns has allowed the CBHC to gather an extraordinary number of powerful partners committed to working together on what is framed as a community issue.

Framing the Problem

Successful social organizers and policy advocates understand the importance of framing the problem they hope to address. The sources and level of support they garner depend largely on how the problem is framed and presented. Leaders of the CBHC have carefully framed health care shortages as both a community crisis and a human rights issue. For example, the organization's Web site states, "Accessible, affordable, quality health care is a basic human right for ALL people," and that, "A health care system that serves the people must come from the people" (CBHC, n.d.). In this way, the discussion is structured such that the interests of the entire community frame both the problem and the solution.

The coalition further implicates the entire community by highlighting the importance of "community health and wholeness" and addressing "the social roots of ill health: poverty, unemployment, poor housing, inadequate education, environment degradation, racism, sexism and homophobia" (CBHC, n.d.). Through this presentation of the problem, the CBHC has tied health care to human rights, social justice, labor, housing, gay rights, education, minority rights, gender, and environmental protection. It is hard to imagine that there are many people who do not claim some affiliation with at least one of the above interests.

For the CBHC, two additional key elements of the health care issue are the cost-effectiveness and public health components of providing preventative health care. In an editorial, coalition leaders assert that having uninsured residents costs more for the community overall and drives up health care costs for everyone (Blackshere et al., 2003). Further, the editorial reports an estimate

from the Institute of Medicine that \$99 billion is spent annually nationwide on health care for uninsured people and that this cost is expected to increase by at least \$34 billion every year. The editorial authors also claim that, “There is a greater success rate for public health and other population-based prevention and early detection strategies,” and that access to regular sources of health care increases “opportunities for cost-saving disease management strategies” (Blackshere et al., 2003).

The CBHC’s chief solution for the health care crisis is to implement a single-payer system in Illinois before expanding it to cover the United States. In the CBHC vision, this system should provide universal and comprehensive coverage, equal access, and culturally sensitive, community based care. It should also be funded by government through taxation. Beyond this, the organization’s stated solutions are rather vague and mixed in with goals: to “make regulatory and legislative changes,” and to “create and advocate for an accessible quality health care system that provides for all” (CBHC, n.d.).

While implementing a single-payer health care system would bring about the CBHC’s goal of universal care, a single-payer system is not likely to be supported by many in the health care and business communities. By framing the problem in the language of economics, human rights, and community health, the CBHC has increased the potential advocate base to include organizations and individuals that may not have previously considered health care a priority. This has enabled the CBHC to bring in groups that have traditionally been in opposing camps.

Leveraging Political Power through Coalitions

In an influential argument, social activists and theorists Richard Cloward and Frances Fox Piven (1999) claim that poor people’s movements cannot make up with numbers what they lack in political power. They write, “To be poor means to command none of the resources ordinarily considered requisite for organization and influence: money, skills, and professional expertise, access to the media, and personal relationships with officials” (p. 168). Thus, in order to achieve political change, these organizations and movements must include “cross-class voting blocs” (p. 168). They also state that community organizing is hampered by its “localistic character” (p. 168). The major victories for low-income, low-power populations have come in national legislation, and national legislative achievements are out of reach for most community efforts.

Consciously or not, the CBHC has integrated these correctives into the organizational strategy without necessarily sharing Cloward and Piven’s conclusion that disruptive action is vital to success. Rather than relying on a

member base of individuals, the CBHC set up the initiative as a coalition-building campaign and brokered relationships with powerful organizations. Through this strategy, the CBHC works within the system of “conventional political resources” to leverage power (Cloward and Piven, 1999, p. 169). Such a structure may help them avoid the pitfalls, such as member attrition, lack of media attention, and limited reach, that other groups face.

This strategy has so far met with success, creating committed partnerships with key players who bring a wide variety of resources to the coalition. Major political partners include the Chicago Department of Public Health, the Cook County Bureau of Health Services, Chicago Mayor Richard M. Daley, and Illinois Governor Rod Blagojevich. Major health care providers, including UnitedHealthcare, the Illinois Hospital Association, and the Illinois Academy of Family Physicians have also partnered with the CBHC, as have representatives of the business community (e.g., the Chicagoland Chamber of Commerce). To this same coalition, the CBHC has brought labor unions, including the AFL-CIO, and activist groups, such as the Urban League and the Chicago Coalition for the Homeless. Through strategic framing of the problem and partnership building, the CBHC has tied in the interests of the middle class and brought together many parties that don't often find themselves on the same side of an issue. The coalition has framed health care access as a cross-class issue, leveraging money, professional expertise, national influence, and social capital not available to many community organizations.

Major successes of the CBHC underscore the importance of the coalition's base. Backed by political clout and major voices in the health care industry, the CBHC helped to push through state legislation including the Health Care Justice Act of 2004, successfully oppose major Medicare and Medicaid cuts by the U.S. Congress, and prevent the closing of public health clinics in Chicago (CBHC, n.d.). The CBHC Web site also reports that the group helped to organize the National Call in Day for Universal Health Care, negotiate better outcomes for consumers in two hospital mergers, delay two other mergers, and expose Medicare abuses by managed care companies in Illinois (CBHC, n.d.). In 2002, the executive director of the CBHC was recognized by health policy group Families USA as Health Care Activist of the Year, and organization leaders have been appointed to both city and state policy taskforces (CBHC, n.d.).

Staying on Track

Access to power and success in the legislative arena does not guarantee, however, that organizational goals are being met. These advantages can actually

distract organizations from their original purpose. It is important to consider how well the CBHC's goals fit the strategies employed. The goals of the CBHC are to sponsor "a tenacious grassroots campaign to educate and involve health care consumers, build coalitions with other organizations who share our commitment to social justice, and make regulatory and legislative changes in the current health care system at the local, state, and national levels" (CBHC, n.d.).

When a universal health care system is in place, the CBHC's goal will become "to monitor and protect the quality, accessibility and affordability" of the system (CBHC, n.d.).

The coalition-building strategy that the CBHC has employed fits well with its goals and has enabled the organization to accomplish several objectives within a relatively short time. There is an inherent tension, however, in bringing big players to the table to broker deals for poor and disenfranchised populations. It is not clear what is meant by "grassroots" in the original formation the CBHC's vision statement nor if the organization has achieved this identity (CBHC, n.d.). It is possible that, by relying on relationships with powerful business and political interests, the CBHC has lessened the directive voice of its poor and uninsured constituents. In spite of access to traditional power sources, the CBHC may have lost a key feature of grassroots initiatives: the power to mobilize communities on the ground.

BUCKING THE SYSTEM: CHALLENGES OF COMMUNITY ORGANIZING

While the CBHC has enjoyed considerable success in the last decade, it also faces many challenges to its community organizing efforts. A primary challenge is ensuring that all voices are heard and truly represented. Ideally, the community initiative would leverage political power in order to bridge the traditional resource gap between the haves and have-nots. That power would provide political access to the poor and disempowered. The risk, however, is that powerful interests will play a larger role in making the CBHC's decisions and the less-organized (and less-powerful) community members will take back seats in the bargaining room. While system change is always difficult, it may be impossible to accomplish by working through the system. Compromises made to engage the business and health care communities may cost the CBHC the support and energy of the uninsured population.

Another challenge confronting the CBHC is the Bush administration's opposition to a single-payer system. The administration instead promotes private-public options, such as tax-free individual health savings accounts and

increased bargaining power for small businesses (Republican National Committee, 2005). While local efforts to regulate Medicaid managed care facilities and to investigate state health care reform options for Illinois are important, these actions do little to bring about national legislation that will provide health care for the uninsured. It is unlikely to happen during the Bush administration; federal policy is actually moving toward increased privatization of health care and more cuts in the Medicare and Medicaid programs, shifting resources and people away from the existing programs (Andrews, 2005; Stolberg, 2005). This will make it increasingly difficult for the CBHC to advance its agenda on the national scale.

The pace of system change can also be a challenge. The process is often slow, particularly when groups are simultaneously working on local, state, and national levels, and when so many competing interests are involved. While the CBHC is pursuing a universal health care plan for Illinois and the United States, the number of people without health coverage continues to rise (DeNavas-Walt, Proctor, and Mills, 2004). The victories along the way do little to actually provide health care for families going without it. The challenge, then, is to maintain motivation and a sense of progress when the numbers aren't changing and so many coalition members don't feel a direct positive impact.

Another key hurdle for the CBHC is the difficulty of uniting groups across class, race, and citizenship. As discussed above, the CBHC's leaders have done an impressive job of bringing capitalists and middle-class blocs into the coalition. However, inadequate access to health care is not just a class issue; it also has racial and citizenship components. It can be difficult to unite across these groups. Additionally, immigration status has become a legal barrier in access to health care. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (U.S. Public Law 104-193) gave states the power to deny benefits (including Medicaid and Medicare) to legal immigrants. At the same time, the act also handed states the responsibility of funding those benefits. Illinois continues to cover legal immigrants under the age of 18 through KidCare but no longer covers adult members of those families or childless adults, regardless of income (Illinois Department of Public Aid, 2004).

These are significant challenges, but coalition leaders can take several crucial steps to maximize the health and vitality of the initiative. A possible first step is to ensure that the uninsured have voices at the CBHC's table and can take a leading role in setting priorities for the campaign. In addition, the CBHC is in a position to forge relationships between members of the uninsured community and the health care industry. By working together toward a common goal of improving health care access, these two groups will

likely minimize efforts (and success in attempts) to demonize each other. Most importantly, the CBHC must be clear about what a grassroots approach means for the organization's identity and must regularly assess whether or not it is maintaining that identity in practice.

Immigration and racial issues can be at least partially addressed by successfully partnering with groups that represent those populations to ensure that their concerns are considered. Important steps in the right direction include partnerships with the Urban League, the Asian Health Coalition of Illinois, Asian Human Services, and many neighborhood groups and community health clinics in immigrant-heavy areas of Illinois. In addition, the CBHC recently conducted an education campaign to increase the cultural competency of health care providers that work with minority and immigrant children covered under KidCare (CBHC, n.d.).

Another potential step for the CBHC is to continue to strengthen relationships with major political operatives during the Bush administration. Though federal health care policy may move against the CBHC's goals for the next few years, the organization can continue to lay the groundwork for major initiatives in 2008. With the right relationships in place and a history of impressive accomplishments, the CBHC may be able to leverage more federal influence in the future. The organization also has an opportunity to frame the way that access to health care is understood in upcoming elections. It must continue to highlight every success along the way and maintain strong coalition relationships.

CONCLUSION

The Campaign for Better Health Care has become a major player in the health care reform field in Illinois over the last decade. Beginning as a small group of concerned individuals, the CBHC has grown into a coalition of over 300 member organizations, leveraging power and influence where it counts most for health care reform: among health providers, business, and labor interests, as well as in politics. The strategic coalition building and commitment to partnerships has allowed the CBHC to win victories in each of these spheres, but the hardest work is still ahead. Establishing a single-payer health care system, maintaining a grassroots identity, and uniting constituents across race and citizenship status are exigent challenges that may require new strategies and organizing skills. The CBHC may have to adapt to changing economic and political structures in order to remain effective and to achieve the organizational goals. ■

REFERENCES

- Alinsky, Saul D. (1941). Community analysis and organization. *American Journal of Sociology*, 46 (6): 797-808.
- Andrews, Edmund L. (2005, April 22). Greenspan urges Congress to rein in federal benefits. *New York Times*, P. C2.
- Blackshere, Margaret, Larry U. Haspel, Michael Brummer, William Moeller, Jim Duffett, Jerry Roper, et al. (2003, Mar. 27). Let's talk about healthcare (Editorial). Retrieved May 5, 2005 from http://www.cbhconline.org/article_healthcare.htm.
- Campaign for Better Health Care (n.d.). About us. Retrieved May 5, 2005 from <http://www.cbhconline.org/aboutus.htm>.
- Campaign for Better Health Care and Families USA (2004). The Health Care Justice Act: What's at stake? (Fact sheet.) Washington, DC: Author. Retrieved May 5, 2005 from http://www.familiesusa.org/site/DocServer/Illinois_Uninsured.pdf?docID=5321.
- Cloward, Richard A., and Frances Fox Piven (1999). Disruptive dissensus: People and power in the industrial age. In Jack Rothman (Ed.), *Reflections on community organization: Enduring themes and critical issues* (pp. 165-93). Itasca, IL: F.E. Peacock.
- Commission on Presidential Debates (2004, Oct. 14). The third Bush-Kerry presidential debate (Transcript). Retrieved on May 5, 2005 from <http://www.debates.org/pages/trans2004d.html>.
- DeNavas-Walt, Carmen, Bernadette D. Proctor, and Robert J. Mills (2004). *Income, poverty, and health insurance in the United States: 2003* (Current Population Reports, P60-226). Washington, DC: U.S. Census Bureau. Retrieved May 5, 2005 from <http://www.census.gov/prod/2004pubs/p60-226.pdf>.
- Families USA (2003). Who's uninsured in Illinois and why? (Fact sheet.) Washington, DC: Author. Retrieved May 5, 2005 from http://www.familiesusa.org/site/DocServer/Illinois_uninsured.pdf?docID=2374.
- Families USA (2004). The uninsured: A closer look (Fact sheet). Washington, DC: Author. Retrieved May 5, 2005 from <http://www.familiesusa.org/site/DocServer/Illinois.pdf?docID=3684>.
- Illinois Department of Employment Security (2004a). Illinois labor force estimates: Annual averages: 1976-2004. Retrieved May 5, 2005 from <http://lmi.ides.state.il.us/laus/annave.htm>.
- Illinois Department of Employment Security (2004b). Annual mass layoffs in Illinois. Retrieved May 5, 2005 from <http://lmi.ides.state.il.us/mls/mls-annual.htm>.
- Illinois Department of Public Aid (2004). Temporary KidCare medical benefits fact sheet. Retrieved on May 5, 2005 from <http://www.kidcareillinois.com/eligibility.html>.
- Republican National Committee (2005). Health care: President Bush's agenda for improving health care. Retrieved May 5, 2005 from <http://www.gop.com/GOPAgenda/AgendaPage.aspx?id=4>.
- Stolberg, Sheryl G. (2005, April 29). Congress passes budget with cuts in Medicaid and in taxes. *New York Times*, p. A1.

NOTE

¹ It is important to note that these statistics reflect the population under 65, as people 65 and over are covered by Medicare.

ABOUT THE AUTHOR

ANDRÉA TAYLOR is a second-year administration student at the School of Social Service Administration and is also in the Graduate Program for Health Administration and Policy. She is a graduate of Wheaton College with a B.A. in anthropology and English literature. Andréa's social work interests include health policy, immigration issues, and international development.

LITERATURE SEARCH AND APPLICATION: INTERVENTIONS FOR CHILDREN WITH INSULIN-DEPENDENT DIABETES MELLITUS

By Bridget M. Colacchio

This article presents the results of a literature search designed to demonstrate the guidelines for conducting an evidence-based investigation as outlined by Leonard Gibbs (2003) and to identify interventions used in the psychosocial treatment of children with insulin-dependent diabetes mellitus (IDDM). The article will also propose strategies to apply and implement those interventions in a treatment plan for patients and families at Children's Memorial Hospital in Chicago. Application and implementation strategies focus on a community-based, family support intervention adapted to fit the needs of the hospital's patient and family population, as well as the parameters of the hospital setting.

Diabetes has come to be associated with obesity, poor eating habits, and lack of exercise. Though bearing similar names, the two types of diabetes—Type I diabetes, or insulin dependent diabetes mellitus (IDDM), and Type II diabetes, or adult-onset diabetes—are quite distinct. The diagnoses, symptom sets, treatments, and prognoses are different. So, too, are the sociocultural perceptions of the two diseases. One such distinction is that IDDM develops during childhood. Like many childhood diseases, there is nothing that a child or a parent can do to prevent or predict the development of IDDM (Grey, Genel, and Tamborlane, 1980; Grey et al., 1995). Thus, the onset of diabetes in children is a shocking and disturbing event for families.

The condition that precipitates discovery of IDDM can be a swift, severe, and frightening sickness in a child. This initial event can be an extremely devastating experience for a family. Research documents the profound physical, emotional, and familial stress that follows the ultimate diagnosis (Auslander et al., 1990; Grey et al., 1995).

At Children's Memorial Hospital in Chicago (hereafter, Children's), much attention is devoted to the newly diagnosed IDDM patient and his or her family.¹ The diabetes team consists of doctors, residents, nurses, certified diabetes educators, social workers, and psychologists. Each member of the team descends upon the often-startled family during their first 2 days at the hospital, offering information and support. Immediately, families learn that their children must control their illness by following a structured regime. This regime includes guidelines for diet, exercise, and blood-sugar level monitoring, as well as for administering insulin and other medications. After the child is stabilized, parents are expected to learn to monitor blood sugar levels and administer insulin shots within 1 day. Families quickly understand that the management of the child's diabetes starts immediately and the illness will affect every part of their lives.

PROBLEM IDENTIFICATION AND CASE EXAMPLE

After the initial discharge from the hospital, the child with IDDM must return to the endocrinology clinic every 3 months for a diabetes checkup. It is during these checkups, or a visit to the emergency room, that the diabetes team may discover that a child's illness is being poorly managed. The author witnessed this phenomenon—particularly in girls between the ages of 9 and 13—on several occasions during her time at Children's. A simple blood test (A1C) is conducted in the clinic and reveals the 3-month average blood sugar level for the child. When that average is too high, the team becomes concerned about how the child and family are dealing with the diabetes on a daily basis. One child, Krista, and her family exemplify a pattern of emotion and behavior that the author found to be common among preadolescent girls and their families as they struggle with the management of the child's diabetes.²

Krista is an 11-year-old Latina female who was diagnosed with IDDM in April 2002. Her A1C level was high at her regular 3-month appointment in the fall of 2004; it was more than twice the recommended level. She and her family were referred to a social worker because Krista's mother mentioned that she and Krista were not getting along well. The mother explained that they were arguing about Krista's diet and, more specifically, said that the girl was yelling at her mother when she reminded Krista not to eat too much or not to eat certain foods. Krista agreed and said that she often became angry with her mother. After some discussion, Krista also admitted that she hated being different from her friends and that she didn't like being on a special diet. She said she got tired of having diabetes. In the same conversation, Krista's mother

expressed her own frustrations with Krista's illness, particularly how arguments around Krista's diabetes care were creating tension in their home. Krista reported that when she gets upset at her mother, she goes to her room by herself and listens to music. She also told the author that she sometimes buries her head in a pillow and cries. The author learned from Krista's mother that her performance in school was also suffering. Krista admitted that she sometimes did not check her blood sugar at school as required. Also, the author inferred from Krista and her mother's stories about the girl's daily routine that Krista was not supervised when checking her sugar at home. In a later session when Krista was not present, her mother volunteered that her relationship with her husband was being strained because she felt he was not an equal partner in attending to Krista's medical needs.

The problems identified through interviews with Krista and her family include unmanaged family stress and negative emotions related to Krista's illness. It was the author's clinical impression that Krista and her parents had not integrated diabetes into their understandings of their lives; they continued to combat the illness and that prevented them from making peace with it. Krista's lapses in medical adherence (i.e., not following her diet, checking her blood sugar regularly, or taking her insulin shots as directed) were also a great concern.

RESEARCH QUESTION

This family continued to struggle, seeking help and guidance in order to effectively address the stress and negative emotions they associated with diabetes. These issues affect Krista and the whole family. In searching for specific resources and counseling interventions to help the family, the author pursued information using a Client-Oriented, Practical, Evidence-Search Question (COPEs question; Gibbs, 2003). According to Leonard Gibbs, the COPEs question is the first step in conducting an effective literature search using online, academic databases. The question is created with specifications of the client type, clinical problem, and intended clinical outcomes for a particular client. Based on Krista's situation, the author formulated the following COPEs question: For 8- to 12-year-old girls newly diagnosed with Type I diabetes, what is the most effective intervention to promote better postdiagnosis self-esteem and adjustment to illness?

LITERATURE REVIEW

Search results indicate that Type I diabetes is a well-studied chronic disease.

Many facets of the illness and the characteristics of its sufferers have been researched and described at length. The author identified three foci of particular interest: (1) descriptions of the population (i.e., children and adolescents with IDDM and other chronic illnesses), (2) problems in this population that are targeted by various interventions, and (3) different types of interventions studied for use with this population.

Descriptive Studies of the IDDM Population

A body of research describes features of chronic childhood illnesses that might also be associated with children with IDDM. Theora Evans (2004) suggests that children with chronic physical conditions (including diabetes) are at risk of unhealthy psychosocial outcomes. Social workers and other clinicians would do well, according to Evans, to use developmental theory and strengths-based assessments of children with chronic illnesses as tools for successful planning of interventions. Two studies (Erstling, 1988; Ell and Reardon, 1990) comment on how emerging medical and other technologies affect the population of chronically ill children. Technology often extends the lives of ill children, and it also offers new possibilities for intervention strategies. Susan Erstling (1988) points out that when families are dealing with the stresses associated with a chronic childhood illness, they often neglect other developmental tasks important to the child's growth. These issues illustrate how chronic illnesses of different kinds can generate similar concerns for families.

Much research has also been conducted specifically within the IDDM population. Exploratory studies provide information regarding common characteristics of the illness and of those who live with it. Wendy Auslander and associates (1990) investigate how a Type I diabetic child's health status and disease management might be associated with certain psychosocial, demographic, and familial factors. They find that control of the diabetes is associated with race, socioeconomic status, family cohesion, and number of parents living in the child's home. More specifically, their analysis indicates that black children from single-parent homes are at higher risk for poor diabetes management than other children. In 1993, Auslander worked with a new team of researchers to find that high levels of family stress and few family resources are associated with poor blood sugar regulation in children with IDDM (Auslander et al., 1993). Family functioning is also the focus of a study by Margaret Grey, Myron Genel, and William Tamborlane (1980). These authors find that parental self-esteem correlates closely with a child's adjustment to his or her diabetes. Another study conducted by Grey and associates (1995) finds that children with IDDM differ from their peers without diabetes

in terms of levels of depression and adjustment. Using scales to measure depression, anxiety, adjustment, and self-perception, the authors discover that children with IDDM experience twice as many depression and adjustment problems as their peers (Grey et al., 1995). These and other descriptive studies of children with IDDM illustrate some of the characteristics and troubles of the childhood diabetes population. Studies of this sort can be useful in guiding the creation of interventions that support families coping with diabetes.

Target Problems

The literature search also yielded information about the different issues faced by children with diabetes (or other chronic illnesses), as well as by their families. Comparing children with epilepsy to children with diabetes, Hoare and Mann (1994) find that children with epilepsy have consistently lower self-esteem and poorer behavioral adjustment to their illness. In general, the author's search findings indicate that self-esteem is a frequently discussed target problem examined by a variety of intervention studies (e.g., Herskowitz, 1990; Daley, 1992). Researchers have also shown interest in children's adjustment and response to their illness. Diana Brown, Kathleen Krieg, and Frances Belluck (1995), for example, study the effectiveness of an intervention strategy on the adaptive and functional responses of children with cystic fibrosis.

In a longitudinal study, Maria Kovacs and colleagues (1990) investigate the relationship between the health status of children with IDDM and their later adjustment to the illness. They find that adjustment (measured by levels of depression, anxiety, and self-esteem) is not associated with a child's number of hospitalizations or the child's blood sugar regulation. Other studies explore intervention effectiveness in terms of its impact on physical health (Campbell and Patterson, 1995), family functioning (Grey et al., 1980; Auslander et al., 1990; Wysocki et al., 1997), and depression (Chernoff et al., 2002). The search results did not identify adherence to medical protocol for diabetes management as a possible target problem. Future studies might examine how other issues, like depression and family conflict, affect a child's medical adherence.

Types of Interventions

To address some of the problems identified above, researchers and clinicians utilize a wide variety of intervention strategies. In an effort to counter low self-esteem in teens with IDDM, Beverly Daley (1992) implements an intervention in which teens are matched by demographic criteria with an insulin-dependent adult. These adults act as sponsors to the teens, meeting with them

for informal visits in order to provide social support, offer validation, and, ultimately, improve medical adherence. Teens in Daley's (1992) experimental group were less likely to agree with statements demonstrating low self-esteem and poor illness adjustment than teens in the control group. Raymonde Herskowitz (1990) discusses another creative intervention strategy: an Outward Bound wilderness experience for people (ages 14-42) with Type I diabetes. During this experience, participants took part in six outdoor challenge courses. Outcome measures suggest modest improvements in diabetes adjustment and self-esteem (Herskowitz, 1990).

In one extremely informative article, Wendy Plante, Debra Lobato, and Romy Engel (2001) review 125 studies describing group interventions for children with chronic medical conditions. They categorize these interventions along one or more of the following program types: emotional support, psychoeducation, adaptation or skill development, symptom reduction, and summer camp (Plante et al., 2001). Plante and associates judge adaptation and skill development groups to be the most "*well-established* [original emphasis] for improving physical symptoms and psychosocial functioning among children and adolescents with diabetes" (2001, p. 439), as compared with the other types of interventions.

Other studies examine family behavioral therapy (Wysocki et al., 1997), medical family therapy (Campbell and Patterson, 1995), and strengths-based, psychosocial family therapy (Erstling, 1988). Findings in each of these studies support the effectiveness of family therapy in the treatment of a variety of individual and familial challenges associated with chronic illness.

Robin Chernoff and associates (2002) conducted a study that combines some of the successful ideas presented above: family-focused, group interventions targeting self-esteem and adjustment via an adaptation and skill-development approach. In that study, families and the community were involved in a support program for chronically ill children. The randomized, controlled trial demonstrates statistical significance in the positive adjustment and mental health outcomes in the experimental subjects. The most significant outcome of this study, improved adjustment, was more pronounced among higher risk children (i.e., higher risk because they had poor self-esteem at the beginning of the program; Chernoff et al., 2002).

INTERVENTION PLAN

In light of the aforementioned literature, the author determined that the study by Chernoff and associates offers the most promising intervention strategy to

achieve the desired outcomes (postdiagnosis self-esteem and adjustment to illness in children with diabetes) delineated in the COPEs question. If the determination is correct, this intervention may yield positive results for Krista and her mother, as well as for other such families.

Intervention Description

Chernoff and colleagues (2002) created and implemented the Family-to-Family Network. Families participating in the intervention program are enrolled for a period of 15 months and, ideally, continue for the program's duration. The intervention is comprised of two concurrent components: one for the children and one for their mothers. The children's component, Kids Involved in Discovery and Sharing (KIDS), involves group work and home visiting. These two elements of KIDS are conducted by child life specialists (CLSs) from the Johns Hopkins hospital in Baltimore. These CLSs lead the children in group activities that reflect the program's objectives. One objective, for instance, involves improving the children's perception of their physical appearance. The group activities (e.g., role plays, reading stories, making a scrapbook, tracing the child's body) focus on helping the children master self-praising messages, such as "what's right with my body," "what I'm good at," and, "liking how I look." In addition to activities in a structured group setting, CLSs also make seven home visits to each family. They make monthly phone calls to the families, distribute newsletters and other correspondence, host periodic lunches for two to four families, and facilitate larger social outings for all of the children and families in the program.

The second component of the Family-to-Family Network focuses on the mothers. This part of the program is facilitated by expert mothers. These women have experience in dealing with a child who has one of the four illnesses. The program refers to them as Network Mothers (NMs). Like the CLSs, the NMs also visit the families (either in the home or out in the community) and initiate contact via phone calls. Both CLSs and NMs work collaboratively in the planning of the family events described above. They meet regularly with one another, and with other team members (doctors and social workers). These meetings ensure that the program is implemented as planned and facilitate a forum for mutual guidance and support among the team.

Two independent sources describe the components of the intervention in additional detail. Munn and colleagues (2000) outline the theoretical framework and applied activities used in the children's component. The second source, an article by Henry Ireys and associates (2001), discusses the details of

the maternal component and presents the maternal outcomes of the intervention study. These sources provide the information necessary to replicate the intervention in another setting, such as Children's Memorial Hospital.

Measurement

The Family-to-Family Network uses four indicators of child mental health to assess each participant at the beginning of the intervention. These indicators are also used to assess the effects of the intervention upon its completion. Children's self-esteem is measured by the Self-Perception Profile for Children (Harter, 1985), which consists of 4 individually scored subscales: physical appearance, social acceptance, athleticism, and global self-worth. A self-report tool, the Children's Depression Inventory (Kovacs, 1992), is used to measure depressive symptoms. The Revised Children's Manifest Anxiety Scale (Reynolds and Richmond, 1978), measuring general anxiety, is also a self-report measure. The final measure is the Personal Adjustment and Roles Skill Scale III (PARS III; Stein and Jessop, 1990), which is completed by the children's mothers. The scale has a total adjustment score and 6 subscales: hostility, anxiety and depression, dependency, withdrawal, productivity, and peer relations. The subscales are scored separately. Chernoff and associates (2002) review these measures for reliability, validity, and consistency. Other well-tested measures of child mental health could be used in place of these four tests, but with caution. In order to maintain the dependability of the intervention as a whole, any other measures must provide equal or greater reliability, validity, and consistency.

Application and Implementation

Several factors demonstrate that the Family-to-Family Network intervention is applicable to the diabetes population at Children's Memorial Hospital. Chernoff and colleagues (2002) identify risk for mental health problems and poor adjustment to illness-related change as concerns in children with chronic illnesses. Sandy Rubovits, a licensed clinical social worker, is the author's clinical social work supervisor at Children's and has worked with the endocrinology team at Children's for 10 years. She commented to the author on October 22, 2004 (Sandy Rubovits, personal communication, October 22, 2004) that the medical team's concerns parallel those mentioned above. These concerns include questions as to how to improve the experience of patients and families after this difficult diagnosis. Within the normal protocol of medical, developmental, and psychosocial services provided by the hospital, not all of the needs of families are being met. The Family-to-Family Network

attempts to address these unmet needs.

Demographics is another factor that promotes the intervention's applicability to Children's. Like the city of Baltimore, MD, where the intervention was first delivered, Chicago is a diverse, urban setting. The intervention's sample was diverse in terms of race and family composition, as well as in respect to socioeconomic status and educational attainment of mothers (Chernoff et al., 2002). Most participants were between the ages of 7 and 11, and were in good to very good health at the time of the study (Chernoff et al., 2002). These demographic characteristics parallel some of those in the patient population of the diabetes program at Children's. The largest group of intervention participants in the study (Chernoff et al., 2002) is associated with diabetes (41 percent). Because the study finds significant benefits with all participants, and most participants were associated with diabetes, the author infers that the intervention would be applicable to the diabetes population at Children's. Race is one demographic inconsistency between the population of the study and that at Children's. Rubovits reported that the racial breakdown of the diabetes program parallels that of the hospital population as a whole (Sandy Rubovits, personal communication, October 22, 2004). Children's serves a greater percentage of Latino families (about one-third of all families served at Children's are Latino; Children's Memorial Hospital, 2003) than the corresponding percentage of Latinos in the study.

The Family-to-Family Network intervention is also compatible with Children's commitment to interdisciplinary leadership. Children's employs CLSs who work on each of the hospital's services and collaborate with all other hospital professionals to deliver care to families. It is certainly conceivable that an interdisciplinary team could work together in the implementation of the Family-to-Family Network. Moreover, Children's endocrinology team of doctors, nurses, social workers, diabetes educators, psychologists, child life specialists, and auxiliary staff are supportive of interdisciplinary initiatives to enhance the overall health and well-being of patients and families (Sandy Rubovits, personal communication, October 22, 2004). Also, expert parents and families are used both formally and informally as important resources at Children's. The hospital often turns to seasoned parents and families to share their wisdom of experience with others in similar health related situations. For these reasons, the author surmises that the Family-to-Family Network could be successfully replicated at Children's.

Conditions for Implementation

While the case is strong for fidelity to the original intervention program,

challenges could impede its implementation at Children's. The analysis of Chernoff and associates (2002) reveals that there is no significant association between the dose of intervention (i.e., the length and frequency of written, phone, and face-to-face contact) and participant outcomes. Chernoff and associates (2002) hypothesize that because most participants received what they call a low dose of intervention, the full potential of the program may not be evident from their results. In response to that observation, the author infers that the dosing standards outlined in the intervention should be similarly followed at Children's.

Chernoff and associates (2002) do not measure patient adherence to medical protocol. This is another serious concern for the diabetes team at Children's because psychosocial issues like self-esteem and adjustment may affect adherence (Sandy Rubovits, personal communication, October 22, 2004). In addition, the intervention offers few opportunities for the involvement of fathers, siblings, and other close family members affected by the illness of their loved one. The author advises revising the methodology of the intervention in order to include these important family members in the program.

Chernoff and associates (2002) also fail to report on analysis of the relationship, if any, between intervention effects and the amount of time from the date of a participant's diagnosis to the start of the program. The researchers exclude children whose diagnoses occurred less than 6 months before the beginning of the program. No data was provided concerning the average months or years elapsed between diagnosis and intervention. Other studies (Kovacs et al., 1990; Grey et al., 1995) indicate that the first 2 years after diagnosis are fraught with difficulty and, thus, are an important time for intervention. Rubovits affirms that families who ultimately struggle with a new IDDM diagnosis will often do so within the first 6 months (Sandy Rubovits, personal communication, October 22, 2004). In order to prevent future postdiagnosis problems, the author recommends that this 15-month intervention be made available to patients within the first 6 months after IDDM diagnosis. The intervention should also be extended into the second year after diagnosis.

Some of the barriers to the implementation of the Family-to-Family Network include limitations of time and money. The intervention would extend the hours of the intervention team and such extensions would require compensation. Hospital employees who already work at least a full 40-hour week could not be expected to work overtime for the implementation of this program. It may be necessary to hire new employees to cover the extra time for running the groups and making home visits. It may also be difficult to ensure that patients and families remain in the program for the entire 15-month

duration. Chernoff and associates (2002) do not consider the possible effects of a rolling admission, but that kind of flexibility might be necessary in order to reach more families at Children's.

CONCLUSION

The relevance of the Family-to-Family Network in the treatment of poor self-esteem and in the adjustment of children with chronic illnesses is supported by the literature. More specifically, the intervention's objectives and methods correspond well with those of the diabetes team at Children's Memorial Hospital. Challenges may arise in implementing this intervention outside of its original context, but the program's potential is promising. If it had been implemented early for Krista's family, it might have been able to mitigate some of the struggles they have experienced since her diagnosis. Perhaps, through the Family-to-Family Network, families like Krista's could get involved in the promotion of health and well-being for other children and families. ■

REFERENCES

- Auslander, Wendy F., Barbara J. Anderson, Jeanne Bubb, Kenneth C. Jung, and Julio V. Santiago (1990). Risk factors to health in diabetic children: A prospective study from diagnosis. *Health and Social Work, 15* (2): 133-42.
- Auslander, Wendy F., Jeanne Bubb, Mary Rogge, Julio V. Santiago (1993). Family stress and resources: Potential areas of intervention in children recently diagnosed with diabetes. *Health and Social Work, 18* (2): 101-13.
- Brown, Diana G., Kathleen Krieg, and Frances Belluck (1995). A model for group intervention with the chronically ill: Cystic fibrosis and the family. *Social Work in Health Care, 21* (1): 81-94.
- Campbell, Thomas L., and Juan M. Patterson (1995). The effectiveness of family interventions in the treatment of physical illness. *Journal of Marital and Family Therapy, 21* (4): 545-83.
- Chernoff, Robin G., Henry T. Ireys, Katherin A. DeVet, and Young Kim (2002). A randomized, controlled trial of a community-based support program for families of children with chronic illness: Pediatric outcomes. *Archives of Pediatrics and Adolescent Medicine, 156* (6): 533-9.
- Children's Memorial Hospital (2003). Small steps...giant steps: Children's Memorial Hospital, Chicago: Annual Report 2003 (Report). Chicago: Author. Retrieved March 7, 2005 from http://www.childrensmemorial.org/hosp_info/annual_reports/AR2003.pdf.
- Daley, Beverly J. (1992). Sponsorship for adolescents with diabetes. *Health and Social Work, 17* (3): 173-82.
- Ell, Kathleen O., and Kathleen K. Reardon (1990). Psychosocial care for the chronically ill adolescent: Challenges and opportunities. *Health and Social Work, 15* (4): 272-82.

- Erstling, Susan S. (1988). Family focused care of childhood chronic illness (Ph.D. Diss.). Pittsburgh: University of Pittsburgh.
- Evans, Theora (2004). A multidimensional assessment of children with chronic physical conditions. *Health and Social Work, 29* (3): 245-48.
- Gibbs, Leonard E. (2003). *Evidence-based practice for the helping professions: A practical guide with integrated multimedia*. Pacific Grove, CA: Brooks/Cole-Thomson Learning.
- Grey, Margaret J., Mary Ellen Cameron, Terri H. Lipman, and Frances W. Thurber (1995). Psychosocial status of children with diabetes in the first 2 years after diagnosis. *Diabetes Care, 18* (10): 1330-36.
- Grey, Margaret J., Myron Genel, and William V. Tamborlane (1980). Psychosocial adjustment of latency-aged diabetics: Determinants and relationship to control. *Pediatrics, 65* (1): 69-73.
- Harter, Susan (1985). *Manual for the self-perception profile for children*. Denver, CO: University of Denver.
- Herskowitz, Raymonde D. (1990). Outward bound, diabetes and motivation: experiential education in a wilderness setting. *Diabetic Medicine, 7* (7): 633-38.
- Hoare, P., and H. Mann (1994). Self-esteem and behavioural adjustment in children with epilepsy and children with diabetes. *Journal of Psychosomatic Research, 38* (8): 859-69.
- Ireys, Henry T., Robin G. Chernoff, Katherin A. DeVet, and Young Kim (2001). Maternal outcomes of a randomized controlled trial of a community-based support program for families of children with chronic illness. *Archives of Pediatrics and Adolescent Medicine, 155* (7): 771-77.
- Kovacs, Maria (1992). Children's depression inventory (CDI) - Manual. North Tonawanda, NY: Multi-Health System.
- Kovacs, Maria, Satish Ivengar, David Goldston, James Stewart, D. Scott Obrosky, and Judith Marsh (1990). Psychological functioning of children with insulin-dependent diabetes mellitus: A longitudinal study. *Journal of Pediatric Psychology, 15* (5): 619-32.
- Munn, Erin K., M. A. Widener, Gina M. Fortunato, and Robin G. Chernoff (2000). *KIDS (Kids Involved in Discovery and Sharing) Program Manual for Child Life Specialists*. Baltimore, MD: Johns Hopkins University, Bloomberg School of Public Health, Department of Population and Family Health Sciences.
- Plante, Wendy A., Debra Lobato, and Romy Engel (2001). Review of group interventions for pediatric chronic conditions. *Journal of Pediatric Psychology, 26* (7): 435-53.
- Reynolds, C.R., and B.O. Richmond (1978). What I think and feel: A revised measure of children's manifest anxiety. *Journal of Abnormal Psychology, 6* (2): 271-80.
- Stein, Ruth E. K., and Dorothy J. Jessop (1990). *Manual for the personal adjustment skills scale III (PARS III)*. Bronx, NY: Albert Einstein College of Medicine.
- Wysocki, Tim, Michael A. Harris, Peggy Greco, Linda M. Harvey, Kelly McDonell, Caroline L. Elder Dauda, et al. (1997). Social validity of support group and behavior therapy interventions for families of adolescents with insulin-dependent diabetes mellitus. *Journal of Pediatric Psychology, 22* (5): 635-49.

NOTES

¹Much of the contents of this article, particularly the materials pertaining to specific procedures, practices, and events at Children's Memorial Hospital, are derived from the author's participation in a master's-level social work field placement at the institution (from Sept. 2004 to May 2005). Thus, the personal experiences and conclusions described herein should not be considered final, objective, or independently verifiable evidence.

²In order to preserve the confidentiality of this study's subjects, the names of all subjects have been changed and the dates of reported events are not disclosed.

ABOUT THE AUTHOR

BRIDGET M. COLACCHIO is a second-year master's candidate at the University of Chicago's School of Social Service Administration. Her professional experience includes working in high school, community mental health, and hospital settings. The impetus for this article came from observing the struggles faced by families of children with Type I diabetes. Ms. Colacchio plans to continue doing therapeutic treatment to children and families in the Hispanic population upon graduation.

ANTI-DRUG LEGISLATION AND THE RISING INCARCERATION OF WOMEN: RECOMMENDATIONS FOR FUTURE SENTENCING REFORM

By Charlotte L. Hamilton

The Anti-Drug Abuse Acts of 1986 and 1988 led to a rapid increase in the number of incarcerated Americans. The rate of female incarceration has risen at a particularly high rate over the past 20 years. This article discusses the evolution of drug sentencing policy since 1986. It looks at characteristics of incarcerated women in order to understand how drug policy has influenced this population. The way women participate in the drug trade interacts with minimum sentencing laws to contribute to the rise in female incarceration. The article concludes with policy recommendations for a more equitable drug sentencing system.

The Anti-Drug Abuse Acts of 1986 and 1988 were enacted to crack down on drug-related crimes and to put more drug offenders behind bars.¹ These acts were a central part of America's War on Drugs. Garry Rolison and associates (2002) describe the War on Drugs as "a mythical drug war initiated in the Reagan era" (p. 132). In fact, drug abuse is a prevalent problem, but the current system does not address it in an effective way.

The Anti-Drug Abuse Acts introduced mandatory minimum sentencing for those who commit drug-related offenses, whether the defendants are high-level drug traffickers or low-level co-conspirators. These mandatory minimum sentences were statutory requirements that those convicted of drug offenses would receive minimum prison sentences based primarily on the type and quantity of drug involved in the offense. In theory, these acts would reduce the number of drug dealers and traffickers, thereby reducing the quantity of drugs available on the street and the crime associated with drug use. Despite these measures, 5 years later, in 1993, the U.S. had one of the highest rates of violent crime in the world (Feldman, 1993). In the same year, only 11.2 percent of

drug defendants were high-level dealers (U.S. Sentencing Commission, 1995), yet incarceration rates more than tripled between 1980 and 2000 (Travis, 2000). Although the number of people being incarcerated for drug-related offenses is steadily increasing, the drug problem is still prevalent, there has not been a significant decrease in rates of violent crime (Harrison and Beck, 2004), and a small proportion of those convicted of drug charges are high-level offenders (U.S. Sentencing Commission, 1995).

Investigating the trends in incarceration since adoption of the acts provides a strong indication as to where the laws went wrong. A particularly disturbing trend can be seen in women's incarceration rates, which have been increasing at a faster pace than those among men. This is especially true for drug offenses. Between 1990 and 1997, the number of women serving time for drug offenses nearly doubled while males serving for drug offenses increased by 48 percent (Van Wormer, 2001). Since 1990, there has been a 48 percent increase of women involved in the corrections system. This is despite the fact that the number of women in prison for violent crimes has decreased (Rolison et al., 2002).

This article examines incarceration rates and the way that women's participation in the drug trade makes them especially vulnerable to the War on Drugs. This effort seeks to evaluate how the policies adopted in the Anti-Drug Abuse Acts of 1986 and 1988 have affected female incarceration rates. The article also considers what makes women susceptible to these policies and attempts to identify which subsets of women are most affected. In light of recent changes to the sentencing laws, this article makes recommendations for future policy changes that will increase the effectiveness and equality of the U.S. drug laws and corrections system.

HISTORY

The Sentencing Reform Act of 1984 (U.S. Public Law 98-473; 98 Stat. 1987) created the United States Sentencing Commission. The act originated in a liberal movement to limit the previously unchecked sentencing power of judges and reduce discrimination in criminal sentencing (Stith and Koh, 1993). Conservative interests allied themselves with this liberal movement to achieve their own goals of lengthening prison sentences and reducing the rehabilitative component of criminal sentencing (Weinstein, 2003).

The 1984 act ordered the commission to create the United States Sentencing Guidelines, which specify ranges for the lengths of sentences and raise the length of sentences for many classes of federal offenses.² With the

adoption of the guidelines, the balance of power shifted in sentencing from judges to the prosecutors, who have an enormous amount of control over a judge's sentencing decision (Weinstein, 2003). The prosecutor decides what charges to bring against a defendant and whether to put forth a motion to mitigate, or shorten, a sentence. The judge decides the sentence based on the offense and whether there is a minimum sentence for that crime, rather than his or her own discretion based on the facts of a case (Weinstein, 2003).

There are only two ways for the judge to mitigate the sentence, or provide what is termed a downward departure: a safety valve provision allows a modest sentence reduction if the offense is the defendant's first, and cooperation (termed substantial assistance) in the investigation or prosecution of others can also significantly reduce a sentence. The prosecutor decides whether or not to accept a defendant's cooperation and whether to make a motion giving the judge the opportunity to depart from guidelines on the basis of cooperation (Weinstein, 2003). Ian Weinstein (2003) finds that about half of downward departures occur because substantial assistance provided by the defendant results in the investigation or prosecution of others. More than one-third of sentences imposed are departures, and over half of these are substantial assistance departures (U.S. Sentencing Commission, 2002*b*).

The Anti-Drug Abuse Act of 1986 also specifies mandatory minimum penalties for those who traffic, import, or possess specified amounts of particular narcotics. The statutes permitted harsher sentences but not more lenient ones (Weinstein, 2003). Discrepancies in the treatment of offenses involving different narcotics by the Anti-Drug Abuse Acts have contributed to the increase in incarceration and the imbalance in the system. The mandatory minimum sentences for crack cocaine and cocaine hydrochloride offenses particularly highlight these inequities.

The 1986 act established 100-to-1 as the ratio of crack cocaine to cocaine hydrochloride, tying that ratio to sentencing requirements. For example, a first-time offender possessing 5 grams of crack cocaine (the equivalent of 50-200 doses) will get a minimum mandatory sentence of 5 years in prison. By contrast, he or she would have to possess 500 grams of cocaine hydro-chloride (the equivalent of more than 10,000 doses) to get the same sentence (Hatsukami and Fischman, 1996). The 1988 act mandated a minimum sentence of 5 years in prison for possession of 5 grams of crack cocaine and a maximum sentence of 1 year in prison for possession of cocaine hydro-chloride or another controlled substance (Hatsukami and Fischman, 1996).

DRUG LAWS AND THE INCARCERATION OF WOMEN

The Anti-Drug Abuse Acts of 1986 and 1988 have been instrumental in putting an ever-growing number of people into prison for longer periods of time than ever before (Thevenot, 1999). About 60 percent of federal prisoners and 23 percent of those in state and local prisons are incarcerated for drug offenses (Thevenot, 1999). Between 1985 and 1990, the amount of time women served in prison increased by 40 percent (Kaplan and Sasser, 1996).

The Bureau of Justice estimates that, if incarceration rates remain the same, 6.6 percent of U.S. residents born in 2001 will be imprisoned at some time during their lifetime (Bonczar, 2003). This statistic is disturbing in and of itself, but the increase in incarcerated women is equally troubling. If rates of criminal behavior among women do not correspond with increases in incarceration, something has gone wrong with the system that sentences them to prison. Moreover, women's incarceration will also affect a generation of children. In 1991, for example, 67 percent of women in state prisons were parents of children under the age of 18 (Kaplan and Sasser, 1996). Approximately 70 percent of these women had custody of their dependent children before going to prison. By contrast, only 50 percent of imprisoned men had custody (Kaplan and Sasser, 1996). These statistics make clear the importance of determining the relationship between U.S. drug policy and the steady increase in the imprisonment of women.

WOMEN'S PARTICIPATION IN THE DRUG TRADE

An investigation of the way women participate in the drug trade elucidates some of the reasons for the rise in female incarceration. Much of the rapid increase in the incarceration of women has to do with drugs. Stephanie Bush-Baskette (1998) finds that the number of women imprisoned for drug offenses rose 433 percent from 1986 to 1991. By contrast, the number of men incarcerated for drug offenses rose over the same period by 283 percent (Bush-Baskette, 1998). The differences between the way men and women participate in the drug trade have played a vital role in the increase of female imprisonment.

The profile of a female offender is very likely to include drug or alcohol abuse, even more so than that of a male offender. This likelihood plays an important role in the susceptibility of women to the current drug laws. Approximately 32.8 percent of incarcerated females are in prison for drug offenses. By contrast, 20.7 percent of males are in prison for drugs (Kaplan and Sasser, 1996). Female offenders are more likely than male offenders to

have a history of drug use, and twice as many of these women as men reported using a major drug daily during the month before their arrest (Kaplan and Sasser, 1996). Over 60 percent of female inmates reported alcohol-related problems (Kaplan and Sasser, 1996). A Bureau of Justice Statistics report finds that approximately one-half of female offenders in state prisons were using drugs, alcohol, or both at the time of the offense for which they were incarcerated (Greenfeld and Snell, 1999).

Many have theorized that women's roles as wives, girlfriends, and friends of drug traffickers have led them to receive sentences out of proportion with their crimes (Bush-Baskette, 1998; Van Wormer, 2001; Rolison et al., 2002). Among imprisoned women in the late 1990s who were sentenced under mandatory minimum laws, nearly half were convicted of conspiracy (Van Wormer, 2001). These women may support their husbands or friends in the drug trade by driving a getaway car or transporting narcotics but, if caught, they face a longer prison sentence than major drug traffickers (Van Wormer, 2001). This is due to the substantial assistance provisions in the drug laws. A higher level drug dealer can provide substantial assistance. For example, the dealer might identify a superior in the drug ring and receive a mitigated sentence. By contrast, a low-level accomplice, the role in which many women find themselves, generally has nobody to turn in and no knowledge to exchange. Such an individual is therefore ineligible for the substantial assistance provisions and receives the full minimum sentence based on the amount of drugs involved in the operation (Bush-Baskette, 1998; Van Wormer, 2001; Rolison et al., 2002). This is also inequitable on another level. Two people who commit the same act of conspiracy can receive different sentences, depending on the quantity of drugs involved. The relationship between the quantity of narcotics and the prison sentence is discussed later in this article.

It is also likely that inequity of power in the drug trade will bring many women down with their drug dealer boyfriends and husbands. Some male drug dealers will turn in their own wife or girlfriend in order to receive a downward departure; this is done whether she was involved in the drug deal or not (Thevenot, 1999; Van Wormer, 2001). According to a report by the Bureau of Justice Statistics, nearly 57 percent of women in state prisons have experienced physical or sexual abuse (Greenfeld and Snell, 1999). Because so many incarcerated women have suffered some form of abuse (physical, emotional, or sexual) at some time in their lives, betrayals by drug-involved partners may reflect a larger history of inequitable power structures in these women's relationships with others (Kaplan and Sasser, 1996; Van Wormer, 2001).

The laws' gender-neutral stance on sentencing has had detrimental effects on a vulnerable population. The Anti-Drug Abuse Acts were designed to target high-level drug traffickers, yet two-thirds of the federal crack cocaine offenders in 2000 were street-level dealers (U.S. Sentencing Commission, 2002a). It is clear that the acts have been ineffective in achieving their goals. They have instead created a larger problem by incarcerating those with the least power in the drug trade for disproportionately long periods of time.

DIFFERENCES IN THE INCARCERATION OF BLACK AND WHITE WOMEN

Despite the fact that the Black population represents about 12 percent of the general population in the United States, Blacks make up approximately 50-60 percent of those incarcerated (Rolison et al., 2002). For women, racial differences in incarceration rates are equally apparent. An African-American woman is 8 times more likely to be imprisoned than a European-American woman and twice as likely as a Latina woman (Van Wormer, 2001). Between 1986 and 1991, the number of Black women imprisoned for drug offenses increased by 828 percent. The increase among White females was 241 percent (Bush-Baskette, 1998).

Rolison and associates (2002) find that, in the early 1990s, Blacks were also more likely than Whites to be in prison for drug offenses. The likelihood that a Black person and a White person would be imprisoned for a violent crime was roughly the same. Therefore, Black women and men have not only been highly represented among incarcerated drug users, they are also more likely to be incarcerated for a drug offense than White men and women.

The differing treatment of crack and powder cocaine offenses has had a significant effect on the racial inequities in the prison population. In 1992, 91.4 percent of crack cocaine offenders were Black. In 2000, 84.7 percent of crack offenders were Black (U.S. Sentencing Commission, 2002a). Rolison and associates find that Black women are particularly affected by harsh sentences for crack cocaine offenses. They posit that this crackdown "criminalized a disproportionate number of Black women" (2002a, p. 139).

Mandatory minimum drug policies have led to sentences that are out of proportion with the severity of crimes. This is evident in the crack and powder cocaine example. In 2000, 74.5 percent of federal crack cocaine offenders were unarmed, and if they were armed, the weapons were rarely used. Only 2.3 percent of crack cocaine offenders used a weapon in the crime (U.S. Sentencing Commission, 2002a). Black women who were imprisoned for drug violations were found to be more likely to be crack dependent than Black women in

prison for violent offenses (Rolison et al., 2002). Statistics do not show a concrete connection between the use of crack cocaine and the perpetration of violence. Therefore, sentence lengths of 5 to 10 years for crack addicts are highly unjust.

In its 1995, 1997, and 2002 reports to Congress, the U.S. Sentencing Commission rejected the 100-to-1 ratio between crack cocaine and powder cocaine (U.S. Sentencing Commission, 1997, 2002*a*). In the Commission's 2002 report, it states, "The Commission firmly and unanimously believes that the current federal cocaine sentencing policy is unjustified and fails to meet the sentencing objectives set forth by Congress in both the Sentencing Reform Act and the 1986 Act" (U.S. Sentencing Commission, 2002*a*, p. 91).

Originally, the 100-to-1 ratio was designed to address perceived differences in the abuse potential of the two forms of cocaine. Crack cocaine's abuse potential was believed to be greater than that of cocaine hydrochloride. Evidence shows that the differential treatment of these offenses may not be warranted, due to the similarities between the two forms of cocaine. Crack cocaine is made by mixing cocaine hydrochloride with an alkaline substance and then heating the mixture. This process forms rocks that are generally smoked (Hatsukami and Fischman, 1996). A study done by Hatsukami and Fischman finds that smoked crack cocaine and intravenously administered cocaine hydrochloride have similar tendencies to produce dependence and negative social and personal consequences (1996). Despite the potential of both forms of cocaine to produce similar negative consequences, crack and powder cocaine offenses still trigger different minimum sentences.

Therefore, despite evidence that crack cocaine is not significantly more addictive or violence-inducing than powder cocaine to warrant the difference in sentences (U.S. Sentencing Commission, 2002*a*), the mandatory minimum sentences nevertheless remain. As the incarceration rates of Black women and the demographics of crack offenders indicate, this system of disparate sentencing has had a disproportionate effect on the Black female population. The majority of these women are not receiving punishments that fit their offenses.

RECENT DEVELOPMENTS

The Supreme Court recently declared the sentencing guidelines system to be a violation of the Sixth Amendment because it allowed judges to make factual findings that could increase sentences beyond the maximum decided by the jury (*U.S. v. Booker* [125 S. Ct. 738]; Greenhouse, 2005). In order to remedy this, the Court called for the guidelines to be advisory, rather than mandatory (Greenhouse, 2005). The effects of this step have yet to play out, but are likely

to be enormous. Several important legislators, including Senator Arlen Specter, the Chairman of the Senate Judiciary Committee, have already declared their intent to review the decision and work toward a new sentencing method (Hulse and Liptak, 2005).

POLICY RECOMMENDATIONS

One of the major goals of this article is to inform future decisions on sentencing methods by reviewing the effects the guidelines have had on the incarceration of women. The first recommendation is to change the sentencing discrepancy between crack and powder cocaine. Although the guidelines are now discretionary, a bias against users of crack cocaine versus powder cocaine users still exists. This is due in part to the differential treatment that these drug offenses receive in sentencing. In 1995, the U.S. Sentencing Commission suggested a 1-to-1 ratio between crack and powder cocaine, but even a 20-to-1 ratio would be significant step (U.S. Sentencing Commission, 1995). This change would increase the amount of crack cocaine involved in an offense before a mandatory minimum sentence could be triggered. A lower ratio would reduce the likelihood that someone only peripherally involved in a drug deal will be imprisoned for an extended period of time when a relatively small quantity of cocaine is involved. Reducing or eliminating the discrepancy between sentence lengths for crack and powder cocaine offenses may also start to even out the glaring inequities in the economic and racial demographics of the prison population.

Any future guidelines should also change the fact that substantial assistance is one of the few ways to receive a reduced sentence. This would restore the balance of power between prosecutors and judges. Currently, prosecutors have the ability to move for a downward departure, but judges are unable to take any action unless this motion has been made (Weinstein, 2003). Weinstein suggests a complete elimination of mandatory minimum sentencing. This is a reasonable option, but measures must be taken to ensure that judicial discretion does not become unchecked, as prosecutorial discretion currently is. A balance must be achieved between the different areas of the legal system. Perhaps this can be accomplished by greater use of review and appeal boards.

A final reform is necessary to reduce the effects of the Anti-Abuse Drug Acts and decrease the rate of incarceration. Specifically, the corrections system must evolve from one that emphasizes punishment to one that focuses on rehabilitation. Incarcerated women and men have a variety of problems that

are unlikely to go away during their imprisonment. These problems include substance abuse, mental illness, and poverty. With the right resources, inmates can begin to work on changing the circumstances that led to their incarceration.

CONCLUSION

The mandatory minimum sentencing policies required by the Anti-Drug Abuse Acts of 1986 and 1988 have led to a massive incarceration of the American population. In particular, women have been imprisoned at an astonishing rate. These changes are due to the interaction of mandatory minimum sentencing laws with ways women participate in the drug trade. The inequality of sentencing for offenses involving crack cocaine and powder cocaine has also affected women, particularly Black women, by sending them to prison for longer, and in numbers that are disproportionately large compared to the corresponding rates among White women. In reforming U.S. drug policy and undoing the damage done by the Anti-Drug Abuse Acts, attention must be paid both to the populations affected by the policies and to the particular needs of these populations. Only in this way can we achieve a just criminal system that puts away offenders for a length of time proportionate to the offense committed and that protects the citizens who are most in need of society's help. ■

REFERENCES

- Bonczar, Thomas P. (2003). *Prevalence of imprisonment in the U.S. population, 1974-2001* (Bureau of Justice Statistics Special Report, NCJ17976). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Bush-Baskette, Stephanie R. (1998). The War on Drugs as a war against Black women. In Susan L. Miller (Ed.), *Crime control and women: Feminist implications of criminal justice policy* (113-29). Thousand Oaks, CA: Sage.
- Feldman, Daniel L. (1993). 20 years of prison expansion: A failing national strategy. *Public Administration Review*, 53 (6): 561-66.
- Greenfield, Lawrence A., and Tracy L. Snell (1999). *Women offenders* (Bureau of Justice Statistics Special Report, NCJ175688). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Greenhouse, Linda (2005, Jan. 13). Supreme Court transforms use of sentence guidelines. *New York Times*, p. A1.
- Hatsukami, Dorothy K., and Marian W. Fischman (1996). Crack cocaine and cocaine hydrochloride: Are the differences myth or reality? *Journal of the American Medical Association*, 276 (19): 1580-88.

- Harrison, Paige M., and Allen J. Beck (2004). *Prisoners in 2003* (Bureau of Justice Statistics Bulletin, NCJ205335). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Hulse, Carl, and Adam Liptak (2005, Jan. 13). New fight over controlling punishments is widely seen. *New York Times*, p. A29.
- Kaplan, Mark S., Sasser, J.E. (1996). Women behind bars: Trends and policy issues. *Journal of Sociology and Social Welfare*, 23 (4): 43-56.
- Rolison, Garry L., Kristin A. Bates, Mary Jo Poole, and Michelle Jacob (2002). Prisoners of war: Black female incarceration at the end of the 1980s. *Social Justice*, 29 (1-2): 131-43.
- Stith, Kate, and Steve Y. Koh (1993). The politics of sentencing reform: The legislative history of the federal sentencing guidelines. *Wake Forest Law Review*, 28 (2): 223-90.
- Thevenot, Chad (1999). *Crises of the anti-drug effort, 1999* (Report). Washington, DC: Criminal Justice Policy Foundation.
- Travis, Jeremy (2000). *But they all come back: Rethinking prisoner reentry* (Sentencing and Corrections: Issues for the 21st Century, no. 7). Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
- U.S. Sentencing Commission (1995). *Special report to the Congress: Cocaine and federal sentencing policy* (Report). Washington, DC: Author.
- U.S. Sentencing Commission (1997). *Special report to the Congress: Cocaine and federal sentencing policy* (Report). Washington, DC: Author.
- U.S. Sentencing Commission (2002a). *Report to the Congress: Cocaine and federal sentencing policy* (Report). Washington, DC: Author.
- U.S. Sentencing Commission (2002b). *2002 sourcebook of federal sentencing statistics*. Retrieved March 26, 2005 from <http://www.uscc.gov/ANNRPT/2002/SBTOC02.htm>.
- U.S. Sentencing Commission (2004). *United States Sentencing Commission guidelines manual*. Washington, DC: Author.
- Van Wormer, Katherine S. (2001). *Counseling female offenders and victims: A strengths-restorative approach*. New York: Springer.
- Weinstein, Ian (2003). Fifteen years after the federal sentencing revolution: How mandatory minimums have undermined effective and just narcotics sentencing. *American Criminal Law Review*, 40:87-132.

NOTES

¹Unless otherwise specified, “Anti-Drug Abuse Acts” and “the acts” will refer in this article to the Anti-Drug Abuse Act of 1986 (U.S. Public Law 99-570; 100 Stat. 3207) and the Anti-Drug Abuse Act of 1988 (U.S. Public Law 100-690; 102 Stat. 4181).

²The Sentencing Reform Act of 1984 calls for the U.S. Sentencing Commission to submit annual amendments to the guidelines to Congress for approval. Once approved, the amendments

become law 180 days after the submission date. The guidelines were first submitted to Congress in 1987 (U.S. Sentencing Commission, 2004).

ABOUT THE AUTHOR

CHARLOTTE L. HAMILTON is a first-year clinical master's student at the School of Social Service Administration. She received her B.A. in English from Wellesley College in 2001. After graduating from college, she worked as an editorial assistant for a legal publisher. Prior to coming to SSA, she did a postbaccalaureate program in psychology at Columbia University, where she developed her interest in the incarceration of women.

GAY AND LESBIAN ADOLESCENT PSYCHOSOCIAL DEVELOPMENT IN URBAN AND RURAL SETTINGS

By Frank Baiocchi

Multiple unique barriers impede normative psychological and social development for gay and lesbian adolescents. Research suggests that geographic location plays a significant role in developmental outcomes for gay and lesbian adolescents. Acknowledging the ways in which urban gay and lesbian adolescents differ from their rural counterparts can provide a deeper understanding of the types of social stigmatization these individuals often internalize. This place-based perspective encourages educators, social workers, and policy makers to develop and implement appropriate social support networks and educational programming to best provide for this vulnerable population.

Adolescents must overcome numerous psychological and social obstacles in order to achieve the sense of personal identity that is an indicator of true adulthood (Newman and Newman, 2003). Conflicts in understanding and expressing one's sexual orientation contribute to the difficulties in this progression. In 1973, the American Psychiatric Association removed homosexuality from the official catalog of mental and emotional disorders (American Psychiatric Association, 1994). Two years later, the American Psychological Association approved a resolution in support of this removal (American Psychological Association, 2004). While it is still unclear how sexual orientation develops, most researchers find that it is not a choice made by the individual, but rather a determined series of genetic, hormonal, and environmental influences upon the person (Frankowski, 2004). Still, a stigma is associated with homosexuality, and that perception pervades contemporary American society (Mallon, 1998; Owens, 1998; Frankowski, 2004).

Robert Owens (1998) demonstrates that gay and lesbian adolescents face distinct challenges in their quest for identity resolution. Societal attitudes

toward gay and lesbian adolescents have a decisive effect on the extent to which these individuals are able to achieve positive developmental outcomes (Newman and Newman, 2003; Frankowski, 2004). Furthermore, research finds that the size of a gay or lesbian adolescent's hometown community influences psychosocial development, and this is particularly true in the United States (D'Augelli and Hart, 1987; Savin-Williams, 1990; Owens, 1998). This article will compare impediments to the maturation process of gay and lesbian adolescents growing up in an urban environment with the impediments faced by their counterparts in rural settings. Analyzing these different geographical influences will allow social work practitioners to more appropriately interact with their gay and lesbian adolescent clients. The analysis may also help to develop an increased understanding of and sensitivity to the geographically related cultural context in which those clients live. As Gerald Mallon notes, "It is the Western culture's belief system that supports the negative myths, stereotypes and misconceptions about gay and lesbian people—not their orientation itself—that is a major life stressor for lesbian, gay, or bisexual people" (1998, p. 124).

SELF-LABELING AND DISCLOSURE

Two distinct concepts are central in gay and lesbian adolescents' considerations of their sexual orientation: self-labeling and disclosure. Self-labeling is the process in which one identifies oneself as gay, lesbian, or bisexual (Newman and Newman, 2003). Disclosure is sharing this information with others (Newman and Newman, 2003). Both of these events feature unique challenges and possible risks. Gay and lesbian adolescents frequently describe a sense of "feeling different" from other children in early childhood, often as early as age 4 or 5 (Owens, 1998, p. 16). As Margaret Schneider and Bob Tremble (1985) note, this can lead to a profoundly uncomfortable state of confusion for the adolescent. Owens (1998) observes that, although there is much variation, some individuals already begin to self-label in early adolescence. Self-labeling is often a two-step process in which an adolescent may first accept his or her sexual identity and then proceed to integrate that identity into a sense of self (Owens, 1998, p. 36).

The second concept involves disclosing sexual identity to friends, family, and the community in which the gay or lesbian adolescent lives. Disclosure, often referred to as coming out, can happen as early as adolescence, although it is perceived to be an "inter-active, ongoing" process that gay men and lesbians continue throughout their entire lives (Ryan and Futterman, 1998, p. 11).

RESEARCH AND STATISTICAL DATA

Statistical data on the number of gay and lesbian adolescents in the U.S. are difficult to gather, as many gay and lesbian youth have not yet self-labeled and therefore do not count themselves as homosexual. This also makes it challenging to measure the percentage of gay and lesbian adolescents growing up in urban environments, or to compare such findings with the percentage of their counterparts living in rural areas. For the current enterprise, relevant information from the 2000 Census is limited to statistics concerning households headed by same-sex couples ("2000 census information on gay and lesbian couples," n.d.). However, it should be noted that 16.7 percent of same-sex couples live in rural areas. By contrast, the corresponding figure is 24.5 percent for opposite sex couples in the United States ("2000 census information on same-sex couples," n.d.).

According to one recent U.S. survey, 4.5 percent of adolescents between the ages of 12 and 18 reported primary sexual attractions to persons of the same sex (Remafedi et al., 1992). Among all adolescents in this survey, 2.5 percent self-labeled as gay, lesbian, or bisexual (Remafedi et al., 1992). While the size of the gay and lesbian adolescent population is difficult to determine, it is important to recognize that gay and lesbian adolescents exist in every possible geographic location within the U.S. and elsewhere ("2000 census information on gay and lesbian couples," n.d.; Owens, 1998). It is also important to note that the needs of gay and lesbian adolescents vary, but some individual needs are associated with the specific context, rural or urban, in which an adolescent lives. (Hindle, 1994; Beard and Hissam, 2002).

COMMON CHALLENGES FACED BY GAY AND LESBIAN ADOLESCENTS

Much of the research on the multiple challenges facing gay and lesbian adolescents has not been delineated by geographical background. In order to demonstrate that urban and rural gay and lesbian adolescents have contrasting perspectives, it is necessary to consider some of the common problems that complicate the struggle of identifying one's sexual orientation. Declarations of sexual identity are individual and internal, but they are also group-based and external, taking place in a political and social context (Chan, 1997). Previous research finds that the self-identification process can lead gay and lesbian adolescents in the U.S. to experience depression, turn to drugs and alcohol, and attempt suicide, all at higher rates than their heterosexual peers (Owens, 1998; D'Augelli, 2002; Frankowski, 2004). Disclosure of one's gay or lesbian

identity to friends, family, or the community creates its own difficulties; the “stigmatization of gender nonconformity” (Frankowski, 2004, p. 1829) can lead to increased levels of stress, violence, running away from home, dropping out of school, and suicidal ideation (Beard and Hissam, 2002; Frankowski, 2004). These problems have been researched across many sociodemographic variables in the U.S., including hometown community size, and are seen as primary complications for gay and lesbian adolescents regardless of geographic location (Savin-Williams, 1990; Beard and Hissam, 2002).

CHALLENGES IN URBAN SETTINGS

Gay and lesbian adolescents who come of age in urban environments face distinct and significant challenges in their self-identity process. The most visible focal points of gay life in the United States are the urban districts where gay men and lesbians congregate—the gay ghettos (LeVay and Nonas, 1995; Owens, 1998). Caitlin Ryan and Donna Futterman (1998) state that as many as 26 percent of all lesbian and gay adolescents report having to leave home as a result of familial conflicts related to their sexual orientation. Many of these adolescents reestablish their lives in an urban setting. For example, homeless shelters in Los Angeles estimate that 25 percent of adolescents living on the street self-identify as lesbian or gay, and that number jumps to 40 percent in Seattle (Kipke et al., 1995). Research does not reveal whether these individuals come to the cities from urban or rural environments, but the urbanization process, including acculturation and adaptation to the norms of residing in a city, contributes to the maturation of the gay or lesbian individual throughout many stages of adolescent development (Owens, 1998).

Stigmatization and feelings of worthlessness are found to be as prevalent in gay and lesbian adolescent city-dwellers as they are among gay and lesbian adolescents in other areas of the country (Savin-Williams, 1990; Owens, 1998). In a study of urban gay and lesbian adolescents by Emery Hetrick and A. Damien Martin (1987), 80 percent of the individuals reported a sense of severe social isolation. Paul Hindle (1994) observes that even though cities often provide specific gathering places for gays and lesbians, they are still targeted as a minority group, held in low esteem by other segments of society, treated differently, and, sometimes, persecuted. The concentration in a particular area of a majority opinion that includes antigay rhetoric can add to the strain felt by gay and lesbian adolescents, as they are still often viewed as “the other” within the confines of a metropolitan area (Hindle, 1994, p. 8).

However, urban gay and lesbian adolescents have greater access than their

rural counterparts to community-based resources. Simon LeVay and Elisabeth Nonas (1995) find that gay and lesbian community centers in many cities provide a secure space outside of the endangering environment of these adolescents' daily lives. Such centers provide adolescents with opportunities to develop feelings of self-worth and to establish a group identity that would be hard to acquire otherwise (LeVay and Nonas, 1995). There are also a number of city public school programs designed to attend to the needs of gay and lesbian youth. These provide counseling, foster integration of these adolescents into the school and the community, and include differences in sexual orientation when addressing values of diversity within educational programming (Savin-Williams, 1990). Whole school systems are currently being developed in urban areas to educate only gay and lesbian adolescents who are having trouble in school due to issues with personal sexual orientation. The Harvey Milk High School in New York City and the Eagle Center in Los Angeles are two examples of these sorts of successful schooling programs (Owens, 1998). Owens (1998) notes that, in spite of these resources, only a small minority of gay and lesbian adolescents takes advantage of them. Participation is deterred by lack of information, misinformation, fear, and social pressure (Owens, 1998, pp. 145-60).

CHALLENGES IN RURAL SETTINGS

In identifying and presenting their sexual orientation, rural gay and lesbian adolescents face different challenges than their urban counterparts. Walter Boulden (2001) states that living in and, specifically, being raised in a rural community shapes how a person views life. Feelings of being different, internalized homophobia, negative attitudes towards gay and lesbian behaviors, and family and community censorship contribute to increased depression among rural gay and lesbian adolescents (Beard and Hissam, 2002). Discrimination against gays and lesbians and external homophobia are often pieces of the accepted social fabric in many rural communities (Boulden, 2001; D'Augelli, 2002). Gay men and lesbians from rural areas report high levels of social and geographic isolation (McCarthy, 2000; Beard and Hissam, 2002). Will Fellows (1996) also sees rigid gender roles, ethnic homogeneity, suspicion of the unfamiliar, racism, religious conservatism, sexual prudishness, and limited access to information as conditions that greatly affect gay and lesbian adolescents (p. ix). Fellows (1996) notes that while none of these qualities is unique to rural settings, they all operate in a "distinctive synergy" within these environments and have a lasting impact (p. ix).

The opportunity for gay and lesbian adolescents to join social groups or activities is restricted due to a lack of a cohesive gay community in rural areas (Boulden, 2001; D'Augelli, 2002). Developing a group identity is also limited in rural areas due to a "lack of access to information, to a public meeting space, and to connections with other [gays and] lesbians" (McCarthy, 2000, p. 75). Linda McCarthy (2000) finds it critical for sexual minorities to have an opportunity to feel connected with a small group of friends and acquaintances. This enables gay and lesbian adolescents to "create, transform, maintain, and reproduce" their identities and communities (Beard and Hissam, 2002).

THE IMPACT ON PSYCHOSOCIAL DEVELOPMENT

Beard and Hissam (2002) find that gay and lesbian adolescents have a more complex psychosocial developmental process than heterosexuals. In fact, Mallon argues that gay and lesbian adolescents often go through completely different developmental processes in regards to individuation and identity formation (Mallon, 1998, p. 126). Furthermore, in contrast to heterosexual adolescents, gay and lesbian adolescents may not experience the same degrees of resolution of the conflicts in Erik Erikson's stages of development (Beard and Hissam, 2002). These variations in development can negatively affect a gay or lesbian individual's ability to adjust to peer culture, experience intimacy, and self-accept. They can also produce increased feelings of vulnerability and insecurity (D'Augelli and Hart, 1987).

Hetrick and Martin (1987) note that, in addition to coping with the usual developmental processes of adolescence, the primary developmental task of the gay or lesbian adolescent is to adjust to a socially stigmatized role. Such stigma causes stress in the individual, and that stress can impede the development of coping strategies (Mallon 1998, p. 126). Prejudice against gay and lesbian sexual orientation also may have consequences that manifest themselves in decreased ego development, levels of anxiety, and overall feelings of distress (Beard and Hissam, 2002).

DEVELOPMENTAL ISSUES FOR URBAN GAY AND LESBIAN ADOLESCENTS

Urban gay and lesbian adolescents have particular difficulties in achieving certain developmental milestones. African-American and Hispanic gay and lesbian adolescents live predominately in urban environments (Owens, 1998). Because they experience a double minority status, these individuals often

encounter developmental complications (Owens, 1998, p. 169). These adolescents often have trouble acclimating to a society in which modeling behavior and tolerant attitudes are not observed in their racial and ethnic minority groups. Resulting consequences for the individual may include negative self-image, internalized homophobia, and social role confusion (Owens, 1998). Owens (1998) suggests that internal and external racist attitudes continue to be prominent issues within urban gay and lesbian communities. Adolescents who experience difficulties integrating their racial or ethnic identities into their self-concept may face internal developmental obstacles (Chan, 1997). Gay and lesbian adolescents fear that disclosure of sexual orientation may lead to isolation and lack of support from their ethnic-minority community (Owens, 1998, p. 169). Furthermore, many ethnic-minority gay and lesbian adolescents feel they are "expected to assimilate into a white gay culture" (Owens, 1998, p. 169). LeVay and Nonas (1995) indicate that these cultural barriers may restrict the full identity development of ethnic-minority gay and lesbian adolescents (p. 151).

As Owens (1998) also points out, the threat of AIDS has become another impediment for many urban gay and lesbian adolescents attempting to achieve a positive sexual identity. Urban gay and lesbian adolescents, and supposedly street-smart runaways, engage in high-risk behaviors with very little, if any, protection. Casual, anonymous sexual contact may be perceived to address needs for acceptance, closeness, support, and physical intimacy. These needs become particularly pressing during the adolescent developmental process (Mallon, 1998, p. 135). Prostitution by sexual-minority youths is also rampant in urban areas. One survey in New York City reports that nearly 25 percent of gay and bisexual youths have bartered sex for drugs or money at some point (Rotheram-Borus et al., 1994). While these problems are not strictly confined to urban areas, they highlight a collective tendency towards self-destructive behavior, which subsequently obstructs normative psychosocial development (Owens, 1998, p. 119).

DEVELOPMENTAL ISSUES FOR RURAL GAY AND LESBIAN ADOLESCENTS

Beard and Hissam (2002) assert that rural gay and lesbian adolescents differ from their urban counterparts in the ways they negotiate the conflicts associated with the developmental process. Due to cultural stigmatization, gays and lesbians in rural areas often experience a delayed response to personal resolution of struggles with self-identity, role confusion, intimacy, and social

isolation (Beard and Hissam, 2002). This delay does not allow them to form positive self-identities and create healthy intimate relationships at appropriate times in the stages of development. The postponement of these normative processes may result in an identity-related “developmental moratorium” for the individual (Professor Sadhna Diwan, personal communication, November 15, 2004).

McCarthy (2000) demonstrates that the development of positive gay and lesbian identity is correlated with opportunities often not found easily in rural settings. Such opportunities include information, social support, and interpersonal connections with other gay men and lesbians. Social group identity formation could be hindered if gay and lesbian adolescents lack these types of resources. Additionally, lesbians often turn to other lesbians for emotional support with personal problems (D’Augelli and Hart, 1987). Beard and Hissam (2002) conclude that the same is essentially also true for gay men. Without these social support systems firmly in place, gay and lesbian adolescents in rural areas may find it difficult to proceed through the developmental milestones necessary to achieve adulthood (Beard and Hissam, 2002).

CONCLUSION

Despite society’s increasing awareness of the diversity of sexual orientations, gay and lesbian adolescents continue to face negative attitudes from many within their communities, regardless of the specific geographic location. Gay and lesbian adolescents struggle to develop under the stress of societal stigmatization that often leads to social, emotional and cognitive isolation (Mallon, 1998, p. 143). By moving beyond the stereotypes and mythology that surround homosexuality, creating social support networks, increasing educational programming, and reaching those individuals outside the usual geographic perimeters of the gay and lesbian community, gay and lesbian adolescents are provided an appropriate opportunity for healthy psychological and social development on their journey towards adulthood. ■

REFERENCES

- 2000 census information on gay and lesbian couples. (n.d.). Retrieved March 7, 2005, from <http://www.gaydemographics.org/USA/USA.htm>.
- 2000 census information on same-sex couples, urban and rural. (n.d.). Retrieved April 27, 2005 from http://www.gaydemographics.org/USA/2000Census_urban_rural.htm.

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychological Association (2004). *Sexual orientation and homosexuality*. Retrieved March 7, 2005 from <http://helping.apa.org/articles/article.php?id=31>.
- Beard, Keith W., and Amy Hissam (2002). The use of Erikson's developmental theory with gay men from rural communities. *Journal of Rural Community Psychology, E5* (2). Retrieved March 7, 2005 from <http://www.marshall.edu/jrcp/JRCP%20Intro%20GLBT/JRCP%20Erikson.htm>.
- Boulden, Walter (2001). Gay men living in a rural environment. *Journal of Gay and Lesbian Social Services, 12* (3-4): 63-75.
- Chan, Connie (1997). Don't ask, don't tell, don't know: The formation of a homosexual identity and sexual expression among Asian American lesbians. In Beverly Greene (Ed.), *Ethnic and cultural diversity among lesbians and gay men* (pp. 240-48). Thousand Oaks, CA: Sage.
- D'Augelli, Anthony R. (2002). Mental health problems among lesbian, gay, and bisexual youths ages 14-21. *Clinical Child Psychology and Psychiatry, 7* (3): 433-56.
- D'Augelli, Anthony R., and Mary M. Hart (1987). Gay women, men, and families in rural settings: Toward the development of helping communities. *American Journal of Community Psychology, 15* (1): 79-93.
- Fellows, Will (Ed.) (1996). *Farm boys: Lives of gay men from the rural Midwest*. Madison: University of Wisconsin Press.
- Frankowski, Barbara L. (2004). Sexual orientation and adolescents. *Pediatrics, 113* (6): 1827-32.
- Hetrick, Emery S., and A. Damien Martin (1987). Developmental issues and their resolution for gay and lesbian adolescents. *Journal of Homosexuality, 14* (1-2): 25-49.
- Hindle, Paul (1994). Gay communities and gay space in the city. In Stephen Whittle (Ed.), *The margins of the city: Gay men's urban lives* (pp. 7-26). Brookfield, VT: Ashgate.
- Kipke, Michele D., Susan O'Connor, Raymond F. Palmer, and Richard G. MacKenzie (1995). Street youth in Los Angeles. *Archives of Pediatric and Adolescent Medicine, 149* (5): 513-19.
- LeVay, Simon, and Elisabeth Nonas (1995). *City of friends: A portrait of the gay and lesbian community in America*. Cambridge, MA: MIT Press.
- Mallon, Gerald P. (1998). Lesbian, gay, and bisexual orientation in childhood and adolescence. In George A. Appleby and Jeane W. Anastas (Eds.), *Not just a passing phase: Social work with gay, lesbian, and bisexual people* (pp. 123-44). New York: Columbia University Press.
- McCarthy, Linda (2000). Poppies in a wheat field: Exploring the lives of rural lesbians. *Journal of Homosexuality, 39* (1): 75-94.
- Newman, Barbara M., and Philip R. Newman (2003). *Development through life: A psychosocial approach* (8th ed). Belmont, CA: Wadsworth/Thomson Learning.
- Owens, Robert E., Jr. (1998). *Queer kids: The challenges and promise for lesbian, gay, and bisexual youth*. New York: Haworth Press.

- Remafedi, Gary, Michael Resnick, Robert Blum, and Linda Harris (1992). Demography of sexual orientation in adolescents. *Pediatrics*, 89 (4, pt. 2): 714-21.
- Rotheram-Borus, Mary Jane, Margaret Rosario, Heino F.L. Meyer-Bahlburg, Cheryl Koopman, Steven C. Dopkins, and Mark Davies (1994). Sexual and substance abuse acts of gay and bisexual male adolescents in New York City. *Journal of Sex Research*, 31 (1): 47-58.
- Ryan, Caitlin, and Donna Futterman (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press.
- Savin-Williams, Ritch C. (1990). *Gay and lesbian youth: Expressions of identity*. New York: Hemisphere.
- Schneider, Margaret, and Bob Tremble (1985). Gay or straight? Working with the confused adolescent. *Journal of Social Work and Human Sexuality*, 4 (1-2): 71-82.

ABOUT THE AUTHOR

FRANK BAIOCCHI holds a Bachelor of Arts degree *cum laude* in liberal studies from the Gallatin School of Individualized Study, New York University. He is currently a first-year student in social administration at the School of Social Service Administration at the University of Chicago, where he is also a student recruitment officer. Before enrolling at SSA, Frank was an actor who performed on Broadway, off-Broadway, and at various regional theaters throughout the country.

CHILD AND ADOLESCENT REFUGEES: DEVELOPMENTAL DIFFERENCES

By Amanda Posner

As they acculturate, refugee children face a distinct set of obstacles that are mediated by certain risk and protective factors. Their experiences differ, however, based on their developmental stage at the time of arrival in the host country. This article discusses the different effects of the refugee experience on the development of children and adolescents. It suggests that change is needed in current intervention programs and services. Such change should recognize and accommodate these differences in order to deliver more effective services.

More than half of the world's refugees are children (Fazel and Stein, 2002), and international migration has become a major social issue in the contemporary world. As these children go through the process of resettlement, there are several risk and protective factors that influence their ability to adjust successfully to their new culture. Children and adolescents experience resettlement, the process of permanently settling in a new country, differently, depending on where the individual is in his or her development. Adolescents and school-aged children face different developmental tasks. This is a seldom recognized fact, and successful interventions must pay more attention to such differences.

THE REFUGEE EXPERIENCE

According to the United Nations High Commissioner for Refugees (UNHCR), on January 1, 2004, an estimated 17,093,361 people were classified as refugees or asylum seekers (UNHCR, 2004). The 1951 Convention relating to the Status of Refugees defined a refugee as a person who, "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside

the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (United Nations, 1954, art. 1, sec. A2). In the past decade, the refugee population has increased tenfold, and it is expected to continue to increase (Fazel and Stein, 2002). Child refugees witness horrific and traumatizing events, live in poor conditions, are forced to leave their countries and often their families, and are forced to assimilate to a new culture. Given the intense experiences of child refugees, it is not surprising that they are at significant risk of developing mental health issues (Fazel and Stein, 2002; National Child Traumatic Stress Network [NCTSN], 2003). The most common of such issues are posttraumatic stress disorder (PTSD) and depression (Richman, 1998; Papageorgiou et al., 2000; Fazel and Stein, 2002; NCTSN, 2003). The problems of the past are also highly significant in shaping the future. This is particularly true as refugee children attempt to successfully assimilate into their new cultures (Messer and Rasmussen, 1986).

RISK AND PROTECTIVE FACTORS

Much of the literature regarding risk and protective factors in the acculturation of refugee children stresses the family as a key influence. Critical factors in identifying the children most at risk are the degree to which a family is intact, whether a parent has died, and whether the parent has been separated from the child (McCloskey and Southwick, 1996). Additionally, refugee children are at risk for mental health problems if one or both parents, especially the mother, suffers from depression or PTSD (McCloskey and Southwick, 1996; Fazel and Stein, 2002). Not surprisingly, the coping abilities of parents also strongly influence the mental health of their children. As Carmelina Barwick, Morton Beiser, and Gary Edwards (2002) state, “The family plays an important role in determining children’s mental health. Refugee children sheltered from stress by parents who adopt a coping style of low dogmatism and low authoritarianism are particularly immune to psychological risks” (p. 42).

Individual risk factors include the number of traumatic events witnessed or experienced by a child, physical health problems from trauma or malnutrition, and PTSD leading to long-term vulnerability in stressful situations (Fazel and Stein, 2002). Some of the notable environmental risk factors are poverty, the number of transitions made by the child between different places, the amount of time taken from flight to resettlement, time spent in refugee camps, and the general cultural isolation that comes from fleeing one’s homeland to take up residence in another country (Fazel and

Stein, 2002). Refugee children are clearly at significant risk of developing mental health problems. They suffer not only the effects of flight from a war zone but also the process of adjusting to a new culture (Fazel and Stein, 2002). These stressors affect the whole family; a child's success in overcoming these risks depends heavily upon the successful adjustment of his or her parents and other family members.

Despite these obstacles, most refugee children adapt to their new countries and display amazing levels of resiliency (Barwick et al., 2002). There are multiple levels at which protective factors operate and enable children to overcome risks. At the individual level, protective factors involve a positive personality disposition, the preservation of self-esteem, and the assertion of personal autonomy (Barwick et al., 2002; Fazel and Stein, 2002). The warmth, cohesiveness, and absence of discord within the family environment can also be a protective influence. This is especially true if children have a secure relationship with a parent who can offer support and encouragement in times of stress (Barwick et al., 2002; Fazel and Stein, 2002). Another important protective factor is support from a like-ethnic community. Refugees who resettle in an area where there is an established community of the same ethnocultural background experience lower levels of distress and are able to receive support within familiar cultural contexts (Barwick et al., 2002). At the broadest level, the host culture provides the backdrop for the child's continued development. That society's openness to diversity and receptiveness to immigrants therefore influences the well-being of the child (Barwick et al., 2002). External societal agencies, such as schools, and individuals, such as counselors and social workers who reinforce a child's coping efforts, can also be important protective factors (Barwick et al., 2002; Fazel and Stein, 2002).

DIFFERENCES BETWEEN CHILDREN AND ADOLESCENTS

The problems of the past are highly significant for the mental health of child and adolescent refugees, but those problems can also affect their ability to become part of the new host culture. Child refugees face different challenges than their adolescent counterparts because childhood involves different stages of development than adolescence. Thus, experience and significance of resettlement processes vary depending on where the individual is in his or her development. Whatever a person's age, it is clear that being a refugee and adjusting to a new culture can have significant effects on individual development.

Adolescent Development

Apart from early infancy, adolescence is the period of most rapid growth and developmental change in the human life cycle (Loughry and Ager, 2001). Thus, given their developmental stage, adolescent refugees may have a more difficult time adjusting to their new cultures than younger children. As Lydia Kovacev and Rosalyn Shute (2004) observe, “For adolescents, these challenges may be especially great, as the non-normative experience of migration is superimposed upon a complex of normative changes such as puberty, a developing sense of identity, and the renegotiation of earlier parent-child relationships” (p. 259). Some of the normative developmental tasks in adolescence include forming a sense of group identity, establishing attitudes about and relationships with peers, and renegotiating relationships with parents or caregivers (Newman and Newman, 2003; Kovacev and Shute, 2004).

During adolescence, individuals face the new psychosocial tasks of allying with specific groups and becoming comfortable functioning as members of these groups (Newman and Newman, 2003). Throughout the process of seeking a group affiliation, adolescents question their identities, values, needs, and personal characteristics (Newman and Newman, 2003). As Barbara Newman and Philip Newman (2003) state, “Perceiving oneself as a competent member of a group or groups is fundamental to one’s self-concept as well as to one’s willingness to participate in and contribute to society” (p. 318). Especially salient for adolescent refugees are issues of ethnic group identity. For many, these issues have not been previously considered, but contact with others in a new country inevitably raises issues of ethnic identity and ethnic group differences (Kovacev and Shute, 2004). Young refugees negotiate multiple worlds, making attitudinal and behavioral changes to fit in with their new peers. While ethnic identity varies across groups, it does have a significant effect on development and individual identity formation, especially during adolescence (Newman and Newman, 2003).

The importance of peer interaction for healthy psychosocial development is also widely accepted. During adolescence, peer groups become more structured. The individual’s relation to the group becomes more defined and more important (Newman and Newman, 2003). The peer group provides support, companionship, a sense of identity, and experience with the opposite sex (Kovacev and Shute, 2004). At this key point in the development of peer relationships, international migration processes can be especially disruptive. Adolescent refugees have experienced the total loss of their former peer support networks and must start over in a new culture (Kovacev and Shute, 2004).

Additionally, most of the peers available to them are from the host culture, and this creates difficulties related to language and other cultural barriers (Kovacev and Shute, 2004). Studies suggest that adolescent refugees have very strong personal investments in their classmates since positive regard from their peers is closely related to the ways they view themselves (NCTSN, 2003; Kovacev and Shute, 2004). Adolescents who do not form relationships with peers in the host culture are at a greater risk for emotional problems (Messer and Rasmussen, 1986), and one study finds that people who migrate during adolescence tend to have fewer friends as adults than those who migrate during childhood or adulthood (Kovacev and Shute, 2004). Lack of social integration can have implications for self-esteem and adjustment; it can also lead to life-long difficulties in work, in the formation of intimate bonds, in anger management, and even in physical health (Newman and Newman, 2003).

The relationship between adolescents and their parents also undergoes a change during resettlement. Because parents and adolescents acculturate at different rates, conflicts over various aspects of the new culture are likely to arise (Messer and Rasmussen, 1986; NCTSN 2003). Some behavioral problems may be acceptable and even expected in the host culture but are met with disapproval at home (Messer and Rasmussen, 1986). Studies have shown that adolescents who have school-based relationships with peers from their host culture are at a higher risk for conflict with their parents (Messer and Rasmussen, 1986; Kovacev and Shute, 2004). In many families, parents' own struggles with acculturation prevent them from providing support or supervision to their adolescent children (NCTSN, 2003). This can lead adolescents to become overly susceptible to negative peer influences, such as substance abuse and gang involvement (NCTSN, 2003).

In addition to these emotional development issues, adolescents experience much physical maturation as they go through puberty. This can cause confusion in adolescent refugees, because many cultures do not recognize adolescence as a separate developmental stage (Messer and Rasmussen, 1986). Some refugees may feel that their life cycles are out of sync—that they have become adults too soon or not soon enough. Additionally, refugee adolescents must deal with these physical changes while negotiating two different cultures. Each culture may have different views about physical changes and their meanings, and expectations for behavior may change to reflect physical maturation (Messer and Rasmussen, 1986).

Childhood Development

During the middle childhood stage of development, from 6 years until the

onset of puberty (usually 11 or 12), children are learning the fundamental skills required for success within their culture (Davies, 2004). In general, the following developmental advances are made during this stage: improved self-regulation, internalization of the self, advances in moral development, increased ability to substitute thinking and words for impulsive action, and increasing peer orientation (Davies, 2004). As they gain confidence in their abilities, children in this stage are able to develop a more realistic view of their potential contributions to the larger community (Newman and Newman, 2003; Davies, 2004). The age at which a child becomes a refugee has a large effect on how the child deals with associated experiences of trauma, loss, and exile. Younger children who experience the disruption of early attachment relationships are more susceptible to developing oppositional traits than children who have had roughly 8 years of normal life prior to these experiences (Hamilton et al., 2004). It has been noted that refugee flight generally disrupts childhood development in two ways; flight breaks the continuity of the socialization process and prevents the child from progressing normally in the acquisition of information and skills (Hamilton et al., 2004).

Skill learning during middle childhood is embedded within social and cultural contexts. As Newman and Newman (2003) discuss, “Children’s beliefs and attitudes about which skills are important, what they should expect of themselves, what others expect of them, and what kinds of competing demands should influence their dedication to skill development all contribute to the levels of performance they are likely to achieve” (p. 267). Thus, adapting and developing new skills within a new social and cultural context are primary tasks for the child refugee. When children reach school age, they have developed more cognitive, emotional, and behavioral resources for handling traumatic situations than they previously possessed, and are often able to externalize the causes and consequences of events, rather than fully internalizing them (Papageorgiou et al. 2000). While the developmental tasks of middle childhood are clearly important, children who become refugees during this time seem to be better equipped to overcome developmental barriers than their older and younger counterparts. However, childhood development among child refugees is adversely affected by the accumulation of risk factors (Loughry and Ager, 2001).

As previously discussed, many risk factors are associated with the refugee and resettlement process. As the number of risk factors increases, it also becomes increasingly likely that a child will experience lasting effects from his or her experiences as a refugee (Loughry and Ager, 2001). These factors, such as the stresses of acculturation and dealing with past traumatic experiences,

affect development.

Asymmetric acculturation, which occurs when children acculturate faster than their parents, forces children to negotiate access to services on behalf of their parents (NCTSN, 2003). This is especially common as parents and children learn the host culture's language. This causes stress to children and disrupts the family order as roles are reversed and parental authority is weakened (Barwick et al., 2002; Davies, 2004; Leavey et al., 2004). Evidence suggests that children are harmed by being placed in this position because they acquire more power while losing parental guidance (NCTSN, 2003). Barwick and associates (2002) also mention that children who arrive in the host country during middle childhood are more likely to adopt the new culture's values and attitudes, causing intergenerational culture clashes that can threaten family stability. The stress of acculturation and the processing of past experiences of trauma lead to the most common mental health problems in school-aged children: PTSD and depression (Messer and Rasmussen, 1986). The overwhelming differences in language, culture, school structure, parent-child relationships, and family values can cause a child refugee to sink into hopelessness and helplessness; the child may also act out with aggressive or disruptive behavior (Messer and Rasmussen, 1986; Fazel and Stein, 2002). Symptoms of PTSD and depression are often long lasting. Many studies of refugee children find that these symptoms persist in the months and years after the child has resettled (Papageorgiou et al., 2000; Leavey et al., 2004). Trauma disrupts a child's cognitive functioning and children who have experienced trauma in the past return to these disruptive states when faced with threatening situations, limiting their access to higher-order reasoning and problem-solving skills (Newman and Newman, 2003). If left untreated, the disruption caused by these experiences can hinder a child's ability to develop the tools that help modulate strong impulses, such as empathy, self-control, and problem-solving skills (Newman and Newman, 2003).

IMPLICATIONS

Children and adolescents are active agents in their own development. Actions to ensure their appropriate involvement in decisions that affect them can support their development of resiliency, efficacy, and self-worth (Loughry and Ager, 2001). Yet simply working with the child or adolescent alone is not enough; these issues must be addressed within the context of the family. A supportive and understanding family and a healthy relationship between parents and children can mitigate many of the negative effects of the resettlement

process. As Matthew Hodes (2002) mentions, “Given children’s dependency and involvement with families and other adults, interventions targeting family and the community will necessarily reduce the risk factors for childhood psychiatric disorder and distress” (p. 204). Additionally, families need extra support in building and maintaining healthy parent-child relationships as roles and cultural norms are challenged. Intervention strategies that recognize this may be more successful.

As previously noted, children going through the refugee resettlement process understand the experience differently than their adolescent counterparts, and the experience has a different impact on the development of children. In order for interventions to be successful, practitioners need to be aware of these differences and design interventions and programs that are sensitive to specific developmental needs. Adolescent refugees have a special set of needs, vulnerabilities, and capacities that are rarely addressed in children’s programs. Because of the developmental processes associated with adolescence, adolescents are particularly at risk and need specific protective measures that are geared toward their experiences. These measures must also recognize the importance of being accepted by a peer group. Such experiences are all too commonly ignored when social service providers plan and implement programs for adolescent refugees (Loughry and Ager, 2001). For school-aged children, schools can play a key role in successful resettlement, and a teacher who takes an interest in the child can have a lasting positive effect on his or her social and emotional development (Fazel and Stein, 2002). While this is still true for adolescents, more important are relationships with peers and acceptance into groups. Given this information, programs for adolescent refugees could include components that would help participants learn to initiate and maintain relationships, both within their own communities and in their host communities. Adolescent programs should also provide healthy and culturally appropriate ways to deal with anger and conflict.

CONCLUSION

The experience of being a refugee and resettling in a new culture creates many challenges. There are several risk and protective factors that influence the effects of this experience on children and adolescents. Additionally, the experience affects the individual development of children and adolescents very differently. To better serve refugees and aid their healthy development, agencies need to make sure that they do not group children and adolescents together in treatment efforts. The problems and adjustment issues of child

refugees should be acknowledged as separate and unique from those of their adolescent counterparts. As these differences are noted and integrated into service delivery, programs should see an increase in successful outcomes. With the number of refugees growing every year, this is an issue that is likely to receive mounting attention. ■

REFERENCES

- Barwick, Carmelina, Morton Beiser, and Gary Edwards (2002). Refugee children and their families: Exploring mental health risks and protective factors. In Fern J. Cramer Azima and Natalie Grizenko (Eds.), *Immigrant and refugee children and their families: Clinical, research and, training issues* (pp. 37-63). Madison, CT: International Universities Press.
- Davies, Douglas (2004). *Child development: A practitioner's guide* (2nd ed.). New York: Guilford.
- Fazel, Mina, and Alan Stein (2002). The mental health of refugee children. *Archives of Disease in Childhood*, 87 (5): 366-70.
- Hamilton, Richard, Angelika Anderson, Kaaren Frater-Mathieson, Shawn Loewen, and Dennis W. Moore (2004). *Interventions for refugee children in New Zealand schools: Models, methods, and best practice* (Report). Wellington: New Zealand Ministry of Education. Retrieved on March 30, 2005 from http://www.minedu.govt.nz/index.cfm?layout=document&documentid=6042&indexid=1108&indexparentid=2107#P5_0.
- Hodes, Matthew (2002). Three key issues for young refugees' mental health. *Transcultural Psychiatry*, 39 (2): 196-213.
- Kovacev, Lydia, and Rosalyn Shute (2004). Acculturation and social support in relation to psychosocial adjustment of adolescent refugees resettled in Australia. *International Journal of Behavioral Development*, 28 (3): 259-67.
- Leavey, Gerard, Kathryn Hollins, Michael King, Jacqueline Barnes, Christopher Papadopoulos, and Kate Grayson (2004). Psychological disorder amongst refugee and migrant school children in London. *Social Psychiatry and Psychiatric Epidemiology*, 39 (3): 191-95.
- Loughry, Maryanne, and Alastair Ager (Eds.). (2001). *Refugee experience—psychosocial training module* (Rev. ed.). Oxford: Oxford University, Refugee Studies Centre. Retrieved on March 7, 2005 from <http://earlybird.qeh.ox.ac.uk/rfgexp/start.htm>.
- McCloskey, Laura, and Karen Southwick (1996). Psychosocial problems in refugee children exposed to war. *Pediatrics*, 97 (3): 394-97.
- Messer, Michael, and Norman H. Rasmussen (1986). Southeast Asian children in America: The impact of change. *Pediatrics*, 78 (2): 323-29.
- National Child Traumatic Stress Network (NCTSN), Refugee Trauma Task Force (2003). *Review of child and adolescent refugee mental health* (White paper). Boston, MA: National Child Traumatic Stress Network.

- Newman, Barbara, and Philip R. Newman (2003). *Development through life: A psychosocial approach* (8th ed.). Belmont, CA: Thompson Learning.
- Papageorgiou, V., A. Frangou-Garunovic, R. Iordanidou, W. Yule, P. Smith, and P. Vostanis (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry*, 9 (2): 84-90.
- Richman, Naomi (1998). *In the midst of the whirlwind: A manual for helping refugee children*. Stoke-on-Trent, UK: Trentham.
- United Nations High Commissioner for Refugees (2004). *2003 global refugee trends: Overview of refugee populations, new arrivals, durable solution, asylum seekers and other persons of concern to UNHCR*. Geneva: United Nations High Commissioner for Refugees, Division of Operational Support. Retrieved on March 30, 2005 from <http://www.unhcr.ch/cgi-bin/texis/vtx/statistics/opendoc.pdf?tbl=STATISTICS&cid=40d015fb4>.
- United Nations, Treaty Series (1954, April 22). Australia, Belgium, Denmark, Federal Republic of Germany, Luxembourg, et al.: Convention Relating to the Status of Refugees. *Treaties and International Agreements Registered or Filed or Reported with the Secretariat of the United Nations*, vol. 189, no. 2545, pp. 137-220.

ABOUT THE AUTHOR

AMANDA POSNER, currently in her first year, is pursuing a dual degree with the School of Social Service Administration and the Harris School of Public Policy Studies. She comes from the West Coast, with a stop-over in New York, where she received a B.A. in anthropology and sociology from Vassar College. Her interests are still forming, but include education policy, community development, and the desire to work with children and adolescents.

HOMEOWNERSHIP AS AN URBAN DEVELOPMENT TOOL

By Nicole Hrycyk

Shortages of affordable housing remain a problem for urban areas throughout the country. One popular remedy is to promote homeownership opportunities among low- and moderate-income and minority households. This article will discuss the problem of affordable housing shortages and its importance in urban development. Then, it will illustrate how homeownership can be used as a tool for urban development, examining both historical and contemporary applications. Finally, the analysis will evaluate the success of these initiatives in urban development and discuss the policy implications of emphasizing homeownership initiatives as urban development tools.

Owning one's home is a central goal of many Americans. However, many people have a difficult time reaching this goal. Finding any type of affordable housing, to own or rent, is difficult. This is particularly true for low-income households. The problem of obtaining affordable housing affects America's urban areas, as land is limited. Because cities need to optimize financially beneficial opportunities, development of affordable housing is often not a priority. A variety of programs attempt to address shortages of affordable housing, but none has been as politically viable in recent years as homeownership initiatives for low-income and minority households. In particular, these policies are "being promoted as an important strategy for regenerating distressed urban neighborhoods" (Harkness and Newman, 2002, p. 597).

This article will examine the factors that have led to shortages of affordable housing and will discuss why these shortages reflect an urban development problem. The work will also consider historical and contemporary homeownership initiatives as tools to promote urban development. The majority of this analysis is devoted to efforts at the national level and will explore how national initiatives have affected urban environments. However, policies specific to Chicago will also be discussed. In addition, the article will evaluate homeownership initiatives and larger lessons for affordable housing policy.

THE DILEMMA: A SHORTAGE OF
AFFORDABLE HOUSING

The lack of affordable housing is not a new dilemma, but it became particularly problematic in the second half of the last century. The National Low Income Housing Coalition (NLIHC) recently reported that one-third of households in the United States, equivalent to 95 million people, had housing problems in 2001 (NLIHC, 2004*a*).¹ The Joint Center for Housing Studies (JCHS; 2003) estimates that 7.3 million homeowners spend more than 50 percent of their income on housing. This problem is one of particular concern for low-income and minority households. Nearly 46 percent of households with housing problems earn less than \$25,000 per year, and 67 percent of people with housing problems have low incomes (NLIHC, 2004*a*).² The NLIHC finds that 87 percent of low-income people in households with housing problems experience housing cost burden. It is estimated that 30 percent of households in metropolitan Chicago are housing cost burdened (Metro Chicago Information Center, 2004).

Housing problems and affordability are compounded by the fact that income from a full-time minimum-wage job does not allow a family to pay fair-market rent for a two-bedroom apartment in any state (NLIHC, 2001). In 2004, in Illinois, the housing wage was \$15.44 for a two-bedroom unit, and in the six-county Chicago metropolitan region, the housing wage was \$17.42 (NLIHC, 2004*b*).³

Housing problems affect low-income owners and renters. Both groups experience housing problems at close to the same rate: 30.2 million low-income owners have housing problems, and there are 33.7 million low-income renters with housing problems (NLIHC, 2004*a*). Other research reports similar findings: Cushing Dolbear (2001*b*) defines housing problems as occupancy of inadequate units or cost burdens above 50 percent of income, finding that 15.5 million households had severe problems in 1999.⁴ Just over half of these households were renters. Housing cost burden is the most frequent housing problem, by far (NLIHC, 2004*a*). Furthermore, extremely low-income households (30 percent or less of AMI) experience the most severe housing problems: 61 percent of this population has severe housing cost burdens (NLIHC, 2004*a*).⁵

With all of this negative data, one might think that the housing market is falling. This is not the case. According to the JCHS (2003), homeowners are refinancing and single-family homes are being built in record numbers. The housing industry is strong, yet millions of families are unable to find adequate

and affordable housing. This is a problem for the nation's families, as well as for its cities.

AFFORDABLE HOUSING SHORTAGES AS AN URBAN DEVELOPMENT PROBLEM

Although shortages of affordable housing are a national problem, these shortages are particularly challenging for urban areas, as 79 percent of the nation's citizens live in or near large urban areas (U.S. Department of Transportation, 2004). One of the key challenges for cities is to develop policies that address this problem while balancing their other concerns. This is particularly complicated because cities are complex entities with multiple constituencies. So too, cities are obligated to comply with federal and state policies.

Housing, at a basic level, is about the availability and affordability of land. Even those who rent are affected when the rising cost or diminishing availability of land results in a rent increase. Paul Peterson (1981) argues that of the three economic factors he cites—land, labor, and capital—land is the only factor that cities are able to control. Cities can determine who builds on land and, through zoning regulations, the types of buildings allowed. Unlike their residents, cities are also bound to the land and the urban environment (Peterson, 1981). Residents may move; cities cannot. For this reason, affordable housing concerns are integral to any plan for urban development. Peterson argues that the city must balance its interests with the needs of its residents. This must take into account the needs of residents from all income levels, as well as those of the business community. Such a balance is particularly difficult to achieve when there is a large income gap between the high- and low-wage earners. It is also difficult, because as Peterson (1981) indicates, one of the city's main interests is enhancing its economic well-being. Since land is the economic factor under the cities control, the city must use land in order to enhance its economic well-being.

In discussing how cities enhance their well-being, Peterson (1981) identifies three types of public policies: developmental, allocational and redistributive. He defines developmental policies as those that enhance the city's economic position by strengthening the local economy and tax base. These are generally well-accepted policies. Allocational policies are usually neutral policies that have neither a positive or negative effect on a community; examples of these include police and fire protection and garbage collection (Peterson, 1981). It is the redistributive policies that Peterson (1981) argues may have a negative impact on a community. Redistributive policies help those perceived to be needy or unfortunate through activities such as welfare

assistance (Peterson, 1981). These policies tax those that are most needed for a successful urban tax base, high- and middle- income households, in order to redistribute the money to low-income households. It follows that if a city's policies do too much to help low-income households (i.e., many redistributive policies or high taxes), the high- and middle-income households will move out of the city to areas where taxes may not be as high. If, by contrast, the policies are geared towards high- and middle-income households, their taxes may be lower but the city will have less revenue and low-income households will need to use more public resources, such as medical care and subsidized housing. It is in this way that taxpayers hold power over a city and its interests; they can move but cities cannot. Peterson (1981) argues that cities need to use their land to attract economic investors, a goal generally not achieved through efforts to provide affordable housing because such efforts may increase taxes. Thus, cities have little incentive to find a solution for the problem of affordable housing shortages because those who hold the power do not create a demand for the services.

Furthermore, cities are not in the best position to develop redistributive policies or provide for their low-income residents. As mentioned above, city residents and businesses can choose to leave, taking the tax base with them (Peterson, 1981). John Mollenkopf (1983) argues that, for this reason, policies geared to assist low-income populations should be federal, not local. Bruce Katz and associates (2003) also consider this potential mobility, arguing that housing policy, in particular, should be regional. If adopted, such policies leave cities free to manage the often-complicated relationships with the many and varied urban constituencies.

Neil Brenner and Nik Theodore (2002) argue that, because the U.S. economy is market-oriented and influenced by Keynesian ideas that allow for government intervention, it is acceptable in today's political environment for the federal government to develop the types of policies that John Mollenkopf (1983) suggests. One focus of current government intervention is seen in the multiple initiatives geared towards promoting homeownership among low-income and minority individuals. These groups are traditionally underserved in a market economy: in a study of 17 metropolitan areas, Michael Stegman, Roberto Quercia, and George McCarthy (2000) find only 30,000 homes were available for purchase to the 200,000 working families that could afford them. The supply of affordable housing does not meet the demand, and the government has deemed it necessary to intervene so that more people will have adequate and affordable housing. There are many strategies aimed at providing a solution to shortages of affordable housing. The current analysis will focus on

the use of homeownership initiatives as urban development tools to help combat these shortages.

HOMEOWNERSHIP AS AN URBAN DEVELOPMENT TOOL

Owning a home has long been viewed as an integral part of the American dream. Widely recognized as a goal in the U.S., it is discussed with rhetoric about investment, stability, and residential development (Rohe, Van Zandt, and McCarthy, 2002). William Rohe and colleagues (2002) also indicate that homeownership is associated with a feeling of increased freedom to do as one pleases in one's home (e.g., decoration) and with greater life satisfaction. This American fascination with homeownership predates the nation's birth; colonists and settlers acquired property by staking claims to parcels of land. Such acquisitions provided the owners with a home, a place to work, and the right to participate in American political life (Marcuse, 1999). Over time, the right to political participation has become disentangled from land ownership. Nevertheless, the American desire to own one's home remains unchanged. Since the Depression, housing policy has played a large role in the development of federal urban policy (Mollenkopf, 1983; Jackson, 1985; Katz et al., 2003). The federal government has implemented a number of programs and policies aimed at increasing the number of people who own their homes. In 1933, President Franklin Roosevelt signed the Home Owner's Loan Act (48 Stat. 128) into law, creating the Home Owners Loan Corporation (HOLC). A year later, enactment of the National Housing Act of 1934 (48 Stat. 1246) created the Federal Housing Administration (FHA; Jackson, 1985; Katz et al., 2003). The HOLC was designed to serve urban needs. It introduced the long-term self-amortizing mortgage, allowing homeowners to pay the same amount over the life of the loan. With the advent of long-term mortgages, purchasing a home became less expensive than renting one. The federal government succeeded in making homeownership more available (Jackson, 1985).

While the HOLC saved countless numbers of people from foreclosure and developed a systematic method of appraisal, it also led to redlining of low-income and minority areas.⁶ Because of such practices, home mortgages were often difficult to obtain in those areas (Jackson, 1985). The FHA adopted the appraisal and lending guidelines outlined by HOLC, thus codifying discriminatory lending. It is important to note that neither the HOLC nor the FHA invented discrimination in lending. Nevertheless, they did institutionalize it at the federal level. Because housing was being built in the suburbs at a rapid

rate, FHA programs also helped to deconcentrate the urban core (Jackson, 1985).

Along with the creation of the HOLC and the FHA, over time, the government has also created government-sponsored enterprises (GSE). The first of these, the Federal National Mortgage Association (Fannie Mae), was created in 1938 (Katz et al., 2003). Fannie Mae purchases homes on the secondary market, resulting in a lower cost to borrowers. In 1968, this entity split into two: one private and one federal. Fannie Mae remained the private entity and the Government National Mortgage Association (Ginnie Mae) became the government entity (Katz et al., 2003). The Federal Home Loan Mortgage Corporation (Freddie Mac) was created in 1970, and serves the savings and loan industry (Katz et al., 2003). The creation of these entities further expanded the mortgage market. The GSEs have always had a stated goal of serving moderate- and low-income households. In 1992, under Title XIII of the Housing and Community Development Act (U.S. Public Law 102-550), Congress specifically charged them with an obligation to promote affordable housing for low- and moderate-income families (Katz et al., 2003). Fannie Mae developed the Community Home Buyers Program, which helps households with incomes no higher than the area median to obtain a 5 percent downpayment and a long-term mortgage (Wyly et al., 2001). In 1994, Fannie Mae announced their “Trillion-Dollar Commitment” (91), identifying the goal of helping 10 million families become homeowners by 2000 (Wyly et al., 2001). They met that goal early and, in 2000, announced the American Dream Commitment, which devoted \$2 trillion over 10 years to increase homeownership rates and serve 18 million families (Listokin et al., 2001; Wyly et al., 2001; Harkness and Newman, 2002). The plan targets new owners in underserved populations and expands the supply of affordable housing in underserved neighborhoods. Fannie Mae also met this goal, and in January 2004, announced an expansion to the American Dream Commitment (Fannie Mae, 2004). In the next 10 years, this expansion will help 6 million families become first-time homeowners. The plan is explicitly geared towards closing the gap between minority and nonminority homeownership rates. Of the 6 million families to be served, 1.8 million of them will be minority families (Fannie Mae, 2004).

The success of Fannie Mae is just one indication that homeownership initiatives and policies have been successful. As Katz and colleagues (2003) report, the number of households that own their homes has grown significantly since 1950, when 47.8 percent of households owned; in 2002, that number grew to 67.9 percent. A U.S. Census Bureau (2005) report for the last

quarter of 2004 places the homeownership rate at 69.2 percent. Although the greater part of this increase has been among upper- and middle-income households, there has also been significant growth among low-income and minority households. Nevertheless, significant gaps remain in low-income and minority homeownership. According to this report (U.S. Census Bureau, 2005), 84.6 percent of families above the median family income owned a home in the last quarter of 2004. Only 52.5 percent of families below the median family income own homes. Among the minority population, 49.1 percent of Blacks and 48.9 percent of Hispanics own their home. By contrast, 76.2 percent of non-Hispanic whites own (U.S. Census Bureau, 2005).

Recent public policy actions have been geared towards closing the gaps in low-income and minority homeownership by eliminating discrimination in lending practices and by making the mortgage market more accessible to low-income and minority households. Enforcement of the Fair Housing Act of 1968 (U.S. Public Law 90-284; 82 Stat. 81) and the Equal Credit Opportunity Act of 1974 (U.S. Public Law 93-495; 88 Stat. 1525) have helped to decrease discrimination (Listokin et al., 2001). The adoption of the Community Reinvestment Act of 1977 (U.S. Public Law 95-128; 91 Stat. 1147) compelled financial institutions to invest some of their profits back into the community in which they are located.

The Home Mortgage Disclosure Act of 1975 (HMDA; U.S. Public Law 94-200; 89 Stat. 1125) was amended in 1989 (U.S. Public Law 101-73; 103 Stat. 183), requiring lenders to report all data from all mortgage applications received. This, other changes to loan appraisals, and agreements to promote fair lending objectives further broadened the housing market (Wyly et al., 2001). The Clinton administration launched the National Homeownership Strategy in 1995 with the goal of achieving a homeownership rate of 67.5 percent by 2000 (Wyly et al., 2001).

In spite of all of the progress in developing fair policies for homeownership, in 1995, the U.S. Census Bureau reported that just 56 percent of households (renters and owners) could afford to purchase a modestly priced home in the area they chose (Savage, 1999). This percentage was lower than those able to buy a house in either 1988 or 1984 (Savage, 1999). However, from 1993 through 1998, minorities accounted for 41 percent of the growth in homeowners (Duda and Belsky, 2002). Loans to low-income homeowners grew in this period by 94 percent, compared to a 52 percent growth among high-income homeowners (Duda and Belsky, 2002). Furthermore, loans to Black buyers grew by 98 percent and by 125 percent to Hispanic buyers

(Duda and Belsky, 2002). This evidence indicates that while homeownership is still difficult to attain for many households, these initiatives are having some effect.

However, the effect of homeownership initiatives on urban development may not be as profound as policy makers prefer. Mark Duda and Eric Belsky (2002) discuss data from the HMDA, demonstrating that most low-income and minority home buyers are buying outside of the central city. Instead, these buyers are opting for the suburbs. Data from the 1993-1999 period shows that of the loans in those years, only about 30 percent went to central cities, and just over half (53 percent) of low-income minority home buyers purchased homes in the suburbs (Duda and Belsky, 2002). In this same time period, one-third of low-income minorities bought homes in low-income areas, while more than half purchased homes in middle-income neighborhoods (Duda and Belsky, 2002). Duda and Belsky (2002) also note that low-income house buyers tend to be at the high end of the low-income threshold. If cities choose to emphasize homeownership initiatives as a primary urban development tool, they may not be as successful as they would like, and they likely will not reach the very poor households.

BARRIERS TO HOMEOWNERSHIP

David Listokin and associates (2001) and Mark Duda and Eric Belsky (2002) identify two primary obstacles to homeownership: low wealth and low income. Low wealth indicates an inability to afford a downpayment or funds to cover other up-front costs (Duda and Belsky, 2002). This can prevent potential homeowners from taking that important first step. Duda and Belsky (2002) indicate that low-income barriers arise from mortgage underwriting, and the maximum allowable total debt-to-income or housing debt-to-income ratios. Other research (Savage, 1999; Collins and Dylla, 2001) indicates lack of income as difficulty or inability in meeting routine monthly household expenses, such as a mortgage payment, utility bills, insurance, and repairs. Bruce Katz and associates (2003) discuss other barriers that low-income and minority households face. These include discrimination, difficulty proving creditworthiness because of poor credit history or lack of a history with mainstream financial institutions, lack of information, language barriers, and cultural barriers. The barriers identified here present additional reasons why policy makers must not focus solely on homeownership initiatives: some households may never be able to access homeownership opportunities.

NATIONAL AND LOCAL INITIATIVES

Researchers argue for supply- and demand-side solutions to address the shortages of affordable housing (Collins and Dylla, 2001; Duda and Belsky, 2002; Katz et al., 2003). A supply-side solution would entail increasing the supply of affordable housing through new construction. Demand-side solutions include many of the options already in place through government policy. For example, demand-side solutions might include low-interest loans, downpayment assistance, and homeownership counseling (Duda and Belsky, 2002). Furthermore, researchers argue that strategies to promote homeownership need to address the financial limitations of families and cannot rely on mortgage innovation alone (Katz et al., 2003). These programs are important for many groups of people and do move households into ownership, but affordable rental development cannot be ignored (Katz et al., 2003).

As discussed above, the federal government has implemented a number of programs and policies that make it easier for low-income and minority households to purchase homes. Urban policies, such as those in Chicago, have expanded upon federal efforts. Apart from tax benefits, mortgage innovations, and several other laws, the nation's primary tool for promoting homeownership is the American Dream Downpayment Initiative (ADDI; HUD, 2005). In December 2003, President Bush signed the American Dream Downpayment Act (U.S. Public Law 108-186; 117 Stat. 2685), which created the ADDI. The initiative authorizes up to \$200 million annually for the fiscal years 2004-2007. Eligible individuals can receive downpayment funds, closing costs, and rehabilitation assistance through this program. Participants are limited to \$10,000 or six percent of the purchase price of the home. Eligible individuals must be first-time home buyers with at or less than 80 percent of the AMI. According to HUD, the ADDI's purpose is to increase the homeownership rate, particularly among low-income and minority households. The program is also intended to help revitalize and stabilize communities (HUD, 2005). While this is a national program, it is administered at the local level through the HOME Investment Partnerships Program.

Using the City of Chicago as an example, this article will outline one city's efforts of administering these federal policies. The City of Chicago's Affordable Housing Plan (City of Chicago, 2003) outlines the city's goals and identifies the programs to be employed as urban development tools. Many of these programs focus on homeownership and complement the national initiatives previously described. The plan articulates goals for the period between

2004 and 2008. Its first step is to build, expanding the production of affordable housing. The plan particularly emphasizes expansion of homeownership opportunities for low- and moderate- income households. Specifically, the city will provide low-cost mortgage financing through New Homes for Chicago, the Chicago Partnership for Affordable Neighborhoods (CPAN), and tax-exempt bonds (City of Chicago, 2003). New Homes and CPAN are funded, in part, through the ADDI and HOME monies.

The New Homes for Chicago program, created in 1994, uses business incentives to encourage developers to build new homes for moderate-income households (City of Chicago, 2005b). These incentives include \$10,000 subsidies per home, a waiver or reduction of assorted building permit and utility connection fees, and the ability to purchase city-owned vacant lots for as little as \$1 (City of Chicago, 2005b). This program employs construction as a tool of neighborhood development and provides subsidies to help families purchase the homes constructed. A 2004 map released by the City of Chicago displays the major homeownership programs for 1999-2003. The New Homes constructions are clustered in the near northwest neighborhoods including Humboldt Park, West Town, and North Lawndale, and on the south side of the city in such neighborhoods as Grand Boulevard, Avalon Park, and Woodlawn. Historically, the west and south sides of the city have experienced the most segregation (McArdle, 2002) and, more recently, have seen influxes of low-income families (Bebow and Olivo, 2005).

While the New Homes program may enable families to purchase a home, they may still live in poor or predominately minority neighborhoods. If families are still living in low-income neighborhoods, they may not have access to resources necessary to travel to jobs, obtain employment in their neighborhood, or obtain a quality education. Additionally, the homes in this program are capped at purchase prices of \$155,000 for single-family homes and \$200,000 for two-flats, which is the term the City of Chicago uses to describe single-family homes that have been converted into two units (City of Chicago, 2005b). Such prices fall well beyond the range affordable for many low-income families. For this program, home buyers may earn up to 120 percent of the AMI. In Chicago this is \$72,350 for a household size of two persons (City of Chicago, 2005b). As mentioned above, the living wage in Chicago is \$17.42 per hour (NLIHC, 2004b). This equates to an annual salary of \$36,234 for full-time employment at 40 hours per week, 52 weeks per year. According to the City of Chicago (2005a, 2005b), 80 percent of the AMI is just over \$40,000. It becomes evident that the prices of the new construction are not within an affordable range for many families.

The CPAN program provides set-aside units for families with incomes up to 100 percent of the AMI.⁷ The city works with developers so that a certain percentage of units in new buildings remain affordable to purchase (City of Chicago, 2005*a*). Eligible buyers in this program can earn up to 100 percent AMI, and households with low and moderate incomes may be eligible for a federal tax credit (City of Chicago, 2005*a*).

The city also assists home buyers through programs such as TaxSmart and the Police Homebuyer Assistance Program (City of Chicago, 2003). The TaxSmart Mortgage Credit Certificate (MCC) provides a federal income tax credit of up to 20 percent of the interest paid on a mortgage (City of Chicago, 2005*c*). The Chicago Department of Housing plan also calls for expanded support in the forms of prepurchase counseling, postpurchase counseling, and foreclosure prevention education (City of Chicago, 2003).

EVALUATION OF HOMEOWNERSHIP

Katz and colleagues (2003) argue that one of the goals of affordable housing policy should be to “promote racial and economic diversity in residential neighborhoods” (p. 4). They contend:

When low-income households are clustered in poor or distressed neighborhoods, their access to educational, economic, and social opportunities is severely limited. Thus, to be truly effective, affordable housing policies should promote racial and economic diversity in residential neighborhoods so that poor and minority households are not isolated from social, educational, and economic opportunities. (Katz et al., 2003, p. 4)

If this is a goal of homeownership policies, the results are mixed. Whether or not policies are able to do achieve this goal depends on two variables: the location of the housing (i.e., which neighborhood) and the effects homeownership on communities (Katz et al., 2003).

Location is an important factor for any household in deciding where to purchase a home. This is no different for low-income or minority households. Actually, location may even be more important for these families. When searching for a home, many households look to location for job accessibility, quality of neighborhood schools, and projected housing appreciation (Duda and Belsky, 2002). Furthermore, a high rate of homeownership promotes neighborhood stability, which can lead to fewer neighborhood social problems (Wyly et al., 2001; Harkness and Newman, 2002). Duda and Belsky’s (2002)

research indicates that 50 percent of owners stay in their home for 10 years or more, so households consider many factors when making the decision to buy. Future homeowner concern for location creates a problem in urban areas because the majority of home buyers, including low-income and minority buyers, are buying in the suburbs (Duda and Belsky, 2002). As discussed above, cities need to maintain residents in order to maintain their economic well-being.

As Duda and Belsky's (2002) research indicates, many (53 percent) low-income minority home buyers are purchasing homes in the suburbs, in areas that are not considered low-income. Although low-income minority households are leaving the central city, this does not reduce the amount of segregation they encounter. In his analysis of minority home purchasing patterns in Chicago, Daniel Immergluck (1998) finds that, in 1995-96, 45 percent of Black home buyers purchased in census tracts where 75 percent or more of the population was Black, an increase from 27 percent in 1990-91. Additionally, he finds that 50 percent of that increase, from 27 percent to 45 percent, was restricted to just 5 percent of all census tracts. While home buyers are choosing to leave the central city, it is interesting to note that, in Chicago at least, low-income renters are remaining in the city; particularly those affected by Chicago's Plan for Transformation (Bebow and Olivo, 2005).

The second variable affecting the goals of affordable housing policy is the impact that homeownership has on communities. William Rohe and colleagues (2002) and Katz and associates (2003) identify some potential impacts: owners, when compared to renters, tend to take better care of their property, and crime often decreases in a neighborhood when the number of homeowners increases. Homeownership is also associated with an increase in commercial activity (Katz et al., 2003), and Rohe and associates (2002) find that owners, again when compared with renters, are happier with their units, have better self-esteem, are in better physical health, and are more likely to participate in voluntary organizations or be active in local politics. Rohe and associates caution, however, that more research needs to be done in this area because some evidence indicates that owning a home is more stressful for families at risk of falling behind on payments. Additionally, Rohe and associates (2002) add that homeownership, in spite of all its benefits, can also serve to lock people into low-income or deteriorating neighborhoods because of the costs associated with moving (Rohe et al., 2002; Katz et al., 2003). Elvin Wyly and colleagues (2001) also address potential problems, discussing the possibility that increases in the number of low-income loans may result in an

increased likelihood of foreclosures and delinquent loans. In fact, some evidence indicates that this may be the case. Robert van Order and Peter Zorn (2002) find that low-income, Black, and Hispanic loan holders default at higher rates than loan holders in other groups.

Among the often-noted advantages of homeownership are the potential benefits to children. A number of studies seek to explore this link. Joseph Harkness and Sandra Newman (2002) find that children's outcomes improve when their parents own a home, regardless of the neighborhood in which the home is located. However, the better the neighborhood of the home, the stronger the outcomes for the children (Harkness and Newman, 2002). Specifically, children of homeowners are less likely than children of renters to experience teen pregnancy and to rely on welfare as adults (Harkness and Newman, 2002). They also have greater educational attainment: children of homeowners are more likely to graduate from high school (Harkness and Newman, 2002); Donald Haurin and colleagues (2002) find that cognitive outcomes for children of homeowners are up to 9 percent higher in math achievement and 7 percent higher in reading achievement when compared with the children's achievement prior to living in an owned home. Additionally, the children of homeowners are more likely to obtain some postsecondary education and to have higher hourly wages (Harkness and Newman, 2002). Donald Haurin and associates (2002) agree with these findings and add that there are fewer behavior problems among children whose parents own their homes than among the children of renters.

ARE HOMEOWNERSHIP INITIATIVES SUCCESSFUL?

There is no doubt that the myriad of homeownership policies has assisted thousands of people in achieving the dream of owning a home. Indeed, these benefits have even begun to reach traditionally underserved populations. More and more, low- and moderate-income households have the opportunity to own.

Do the gains identified above justify the current emphasis on homeownership strategies as effective urban development tools? The results are varied. Owners tend to buy outside of the central city and often remain segregated, both racially and economically (Duda and Belsky, 2002). Bruce Katz and colleagues (2003) suggest that some economic integration has occurred, even if racial integration has not. They note that while Blacks and Hispanics tend to purchase homes in neighborhoods where they make up a majority of the

population, low-income households are purchasing in suburban middle-income areas (Katz et al., 2003). As people leave the city to purchase homes, cities face a dilemma; they need to retain residents in order to prosper. There is also a potential for regional problems, as neighboring suburbs may resent the influx of low-income households.

Bruce Katz and colleagues (2003) indicate that regionally structured homeownership policies have limited success. They suggest that the locations of affordable housing are found in clusters of low-income or distressed neighborhoods (as seen in the City of Chicago's programs discussed above). This leads to concentrations of low-income households and is not balanced growth (Katz et al., 2003). On the other hand, Katz and associates (2003) argue that, at the neighborhood level, these policies to promote homeownership have positive effects, evidenced by the outcomes described above.

The movement of buyers to the suburbs lends support to the idea that housing policies should be regional in nature. Cities need to work within their metropolitan areas to promote balanced growth. As more people purchase homes in the suburbs, urban areas stand the potential for economic losses. Policies developed and implemented consistently throughout a region allow for greater financial opportunities (such as jointly funded initiatives), as the city and suburbs can pool resources to address urban development issues. Further research should examine how regional affordable housing initiatives could garner broad-based support and determine if these policies make it easier for the city to hold on to its tax base.

Because homeownership can have a variety of positive neighborhood and individual outcomes, policies should continue to promote homeownership initiatives. However, affordable housing policy should not focus exclusively on homeownership initiatives because they do not effectively reach everyone, particularly the extremely low-income households struggling to find affordable housing. As Wylie and colleagues (2001) point out, "Homeownership is not a panacea for the complex problems that confront individuals and communities in the inner city. But for better or worse, it has become the central point of agreement across the political spectrum and among public, private, and non profit institutions" (p. 97). In working to remedy the current housing problems, homeownership initiatives should continue to be one tool in the affordable housing toolbox. ■

REFERENCES

- Bebow, John, and Antonio Olivo (2005, Feb. 27). CHA moves tenants out—but not up; Ex-residents still live in struggling, segregated areas. *Chicago Tribune*, p. A1.
- Brenner, Neil, and Nik Theodore (2002). Cities and the geographies of 'actually existing neoliberalism'. In Neil Brenner and Nik Theodore (Eds.), *Spaces of neoliberalism: Urban restructuring in North America and Western Europe* (pp. 2-32). Malden, MA: Blackwell.
- City of Chicago, Department of Housing (2003). *Build, preserve, lead: A housing agenda for Chicago's neighborhoods, affordable housing plan 2004-2008*. Chicago: Author.
- City of Chicago, Department of Housing (2004). *Major homeownership programs 1999-2003* (Map). Chicago: Author.
- City of Chicago, Department of Housing (2005a). *Affordable Condos—CPAN* (Report). Retrieved on May 5, 2005 from the Department of Housing Web site through <http://www.cityofchicago.org>.
- City of Chicago, Department of Housing (2005b). *New Homes for Chicago* (Report). Retrieved on May 1, 2005 from the Department of Housing Web site through <http://www.cityofchicago.org>.
- City of Chicago, Department of Housing (2005c). *TaxSmart Mortgage Credit Certificate*. Retrieved on May 1, 2005 from the Department of Housing Web site through <http://www.cityofchicago.org>.
- Collins, J. Michael, and Doug Dylla (2001). Mind the gap: Issues in overcoming the information, income, wealth, and supply gaps facing potential buyers of affordable homes (Report, Home Ownership 2000: Research Series). LISC Center for Home Ownership and the LISC Knowledge Sharing Initiative, Washington, DC.
- Dolbear, Cushing N. (2001a). Housing affordability: Challenge and context. *Cityscape: A Journal of Policy Development and Research*, 5 (2): 111-30.
- Dolbear, Cushing N. (2001b, Nov. 20). Housing problems by tenure and income range (Memorandum). Retrieved on May 5, 2005 from <http://www.nlihc.org/pubs/housingprobs.pdf>.
- Duda, Mark, and Eric S. Belsky (2002). Anatomy of the low-income homeownership boom in the 1990s. In Nicolas P. Retsinas and Eric S. Belsky (Eds.), *Low-income homeownership: Examining the unexamined goal* (pp. 15-63). Washington, DC: Brookings Institution.
- Fannie Mae (2004, Jan. 27). Fannie Mae launches major initiative to tackle America's toughest housing problems: Pledges to help raise minority homeownership rate to 55 percent over next ten years (Press Release). Fannie Mae, Washington, DC. Retrieved on May 5, 2005 from <http://www.fanniemae.com>.
- Harkness, Joseph, and Sandra J. Newman (2002). Homeownership for the poor in distressed neighborhoods: Does this make sense? *Housing Policy Debate*, 13 (3): 597-630.
- Haurin, Donald R., Toby L. Parcel, and R. Jean Haurin (2002). Impact of homeownership on child outcomes. In Nicolas P. Retsinas and Eric S. Belsky (Eds.), *Low-income*

- homeownership: Examining the unexamined goal* (pp. 427-46). Washington, DC: Brookings Institution.
- Immergluck, Daniel (1998). Progress confined: Increases in Black home buying and the persistence of residential segregation. *Journal of Urban Affairs*, 20 (4): 443-57.
- Jackson, Kenneth T. (1985). *Crabgrass frontier: The suburbanization of the United States*. New York: Oxford University Press.
- Joint Center for Housing Studies (JCHS; 2003). The state of the nation's housing: 2003 (Report). Harvard University, Joint Center for Housing Studies, Cambridge, MA. Retrieved on May 5, 2005 from <http://www.jchs.harvard.edu/publications/markets/son2003.pdf>.
- Katz, Bruce, Margery Austin Turner, Karen Destorel Brown, Mary Cunningham, and Noah Sawyer (2003). Rethinking local affordable housing strategies: Lessons from 70 years of policy and practice (Discussion Paper). Brookings Institution, Center on Urban and Metropolitan Policy and Urban Institute, Washington, DC.
- Listokin, David, Elvin K. Wyly, Brian Schmitt, and Ioan Voicu (2001). The potential and limitations of mortgage innovation in fostering homeownership in the United States. *Housing Policy Debate*, 12 (3): 465-513.
- Marcuse, P. (1999). Housing movements in the USA. *Housing, Theory and Society*, 16 (2): 67-86.
- McArdle, Nancy (2002). Race, place, and opportunity: Racial change and segregation in the Chicago metropolitan area: 1990-2000, part 1 (Report). Harvard University, Civil Rights Project, Cambridge, MA.
- Metro Chicago Information Center (2004). Housing burden an issue no matter where you live in the region (Report). Chicago: Author.
- Mollenkopf, John H. (1983). *The contested city*. Princeton, NJ: Princeton University Press.
- National Low Income Housing Coalition (NLIHC; 2001). Out of reach 2001: America's growing wage-rent disparity (Report). Washington, DC: Author.
- National Low Income Housing Coalition (NLIHC; 2004a). America's neighbors: The affordable housing crisis and the people it affects (Report). Washington, DC: Author.
- National Low Income Housing Coalition (NLIHC; 2004b). Out of reach 2004 (Report). Washington, DC: Author.
- Peterson, Paul E. (1981). *City Limits*. Chicago: University of Chicago Press.
- Rohe, William M., Shannon Van Zandt, and George McCarthy (2002). Social benefits and costs of homeownership. In Nicolas P. Retsinas and Eric S. Belsky (Eds.), *Low-income homeownership: Examining the unexamined goal* (pp. 381-406). Washington, DC: Brookings Institution.
- Savage, Howard A. (1999). *Who could afford to buy a house in 1995?* (Current Housing Reports no. H121/99-1). Washington DC: U.S. Department of Commerce and U.S. Census Bureau. Retrieved on May 5, 2005 from <http://www.census.gov/prod/99pubs/h121-991.pdf>.
- Stegman, Michael A., Roberto G. Quercia, and George McCarthy (2000). Housing America's

- working families (New Housing Century 1, no. 1). Center for Housing Policy and National Housing Conference, Washington, DC.
- U.S. Census Bureau (2005, Jan. 27). Census Bureau Reports on Residential Vacancies and Homeownership (Press Release). Washington, DC: U.S. Department of Commerce. Retrieved on May 5, 2005 from <http://www.census.gov/hhes/www/housing/hvs/qtr404/q404prss.pdf>.
- U.S. Department of Housing and Urban Development (HUD; 2003). *Public housing occupancy guidebook*. Washington, DC: Author.
- U.S. Department of Housing and Urban Development (HUD; 2005). American Dream Downpayment Initiative. Retrieved on March 26, 2005 from <http://www.hud.gov/offices/cpd/affordablehousing/programs/home/addi/index.cfm>.
- U.S. Department of Transportation (2004, Feb. 9). Census 2000 population statistics: U.S. population living in urban vs. rural areas. Washington, DC: Author. Retrieved on May 5, 2005 from <http://www.fhwa.dot.gov/planning/census/cps2k.htm>.
- Van Order, Robert, and Peter Zorn (2002). Performance of low-income and minority mortgages. In Nicolas P. Retsinas and Eric S. Belsky (Eds.), *Low-income homeownership: Examining the unexamined goal* (pp. 322-47). Washington, DC: Brookings Institution.
- Wyly, Elvin K., Thomas J. Cooke, Daniel J. Hammel, Steven R. Holloway, and Margaret Hudson (2001). Low- to moderate-income lending in context: progress report on the Neighborhood impacts of homeownership policy. *Housing Policy Debate*, 12 (1): 87-127.

NOTES

¹“Housing problems” are defined by the NLIHC as high cost burden, overcrowding, poor quality, and homelessness. They define “housing cost burden” as the expenditure of more than 30 percent of household income on housing costs. The NLIHC’s definitions of housing problems and housing cost burden will be used in this study.

²The U.S. Department of Housing and Urban Development (HUD) defines low-income households as those earning equal to or less than 80 percent of the area median income (AMI; HUD, 2003).

³“Housing wage” is defined as the hourly wage a worker must earn to afford a two-bedroom home at fair market rent (NLIHC, 2004*b*).

⁴Dolbeare elsewhere defines inadequate units as severely or moderately inadequate, based on the number and seriousness of physical problems including lack of plumbing, heating, or electricity, problems in the hallways or upkeep of the building (Dolbeare, 2001*a*).

⁵“Severe housing cost burden” is defined by the NLIHC as spending more than 50 percent of household income on housing (NLIHC, 2004*a*).

⁶The HOLC developed a neighborhood quality rating system that assigned colors to each category. Red was assigned to the fourth and lowest category of neighborhoods. Neighborhoods

were rated by HOLC and with the assistance of local realtors and banks and a line (in the appropriate color) was drawn around each neighborhood on a secret Residential Security Maps kept in local HOLC offices. It became difficult to obtain a mortgage in an area of the map with the red line around it, hence the term “redlining” (Jackson, 1985).

⁷Set-aside units are those for which a developer reduces the price to an affordable level. Under the program, a certain percentage of units are set aside in a market-rate development.

ABOUT THE AUTHOR

NICOLE HRZYK, A.M. '04, a Presidential Management Fellow, works for the U.S. Department of Health & Human Services. A McCormick Tribune Fellow at the School of Social Service Administration, she concentrated in policy analysis and community development. Nicole holds a B.S. in psychology from North Central College in Naperville, IL. She served in the Lutheran Volunteer Corps and worked in the housing and mental health fields. Her interests include housing, homelessness, mental illness, and social justice.

SUBSTANCE ABUSE TREATMENT: AN ORGANIZATIONAL PERSPECTIVE

By Melissa Walker

Submitted March 2005 to the faculty of the University of Chicago
School of Social Service Administration

CHAIR: Michael R. Sosin, Ph.D., Emily Klein Gidwitz Professor

Drug abuse affects over five million Americans. It is a chronic condition that involves serious medical, mental health, and social problems. Treatment studies have found reduced drug use when clients remain in treatment longer. Research has also shown that positive outcomes are more likely when programs offer a range of services.

This study involves GEE (generalized estimating equations) analysis of survey data collected from a representative national sample of approximately 2,000 outpatient drug addiction treatment programs. Since some programs are represented in more than one survey, GEE was used. Multiple imputation was used to create complete data sets with no missing responses.

From the perspective of the organization theory that guides this research, programs depend on their environment for funding, clients, and other resources. This analysis suggests arrangements that sustain the flow of resources could affect treatment duration and service delivery. Although studies reviewed here have found treatment and offering a range of services both benefit clients, GEE analysis of complete data sets with no missing responses shows programs do not necessarily engage in these activities.

Following an expectation should, institutional theory and resource dependence predict, contribute to programs' legitimacy and reduce uncertainty that surrounds resource acquisition. GEE analysis shows this may be the case with respect to the number of services programs offer clients. A larger proportion of public support was associated with offering a range of services. Programs that received a larger proportion of their support from public sources

reported they delivered more counseling sessions over the course of clients' treatment.

Meanwhile, experiencing an increase in competition had a negative effect on treatment duration. Addiction treatment programs, like most human service organizations, manage many different relationships. This could prevent treating clients longer from becoming a commonly held goal. It could leave programs to mediate the contingencies of their environment themselves. The amount of time clients remain in treatment may be an unintended consequence of programs managing many different relationships. This is what the treatment duration analysis suggests.

The policy implication may be programs could be more likely to engage in activities treatment studies have found associated with better client outcomes when funding arrangements, professional norms and programs themselves recognize the value of these approaches. ■

ABOUT THE AUTHOR

MELISSA WALKER completed her dissertation at the School of Social Service Administration in March 2005. Michael Sosin chaired her dissertation committee. Susan Lambert and Thomas D'Aunno also served as committee members. She plans to continue to pursue research interests that involve organization theory and nonprofit human service organizations.

THE SCHOOL OF SOCIAL SERVICE ADMINISTRATION



SSA/CHICAGO

THE UNIVERSITY OF CHICAGO
969 East 60th Street
Chicago, Illinois 60637

Nonprofit Org.
U.S. Postage Paid
Chicago, IL
Permit No. 7664

Advocates'
FORUM
10TH ANNIVERSARY ISSUE
2005

