PRACTICE & RESEARCH

Studies in Progress

JOURNAL OF THE CENTER FOR THE STUDY OF SOCIAL WORK PRACTICE

PRACTICE & RESEARCH

CURRENT RESEARCH

This Issue of *Practice & Research:* Our Future

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In contrast to the last issue of the *Practice & Research Journal*, which celebrated the Center's tenth anniversary, featuring its major accomplishments and significant contributions to its growth, this issue anticipates the Center's future. Clearly, the character of our current research preoccupations best predicts the Center's future. This issue of the *Practice & Research Journal*, with articles written by Center researchers, demonstrates the vitality, diversity, and breadth of the Center's current research programs. The research reported by Bacon, Blitz, Chapman, DeVoe and Borges, Francoeur, Guterman, Menefee, and Rivard all involve collaboration between agency practitioners and faculty. The research of Moreno, Shibusawa, Walters and Wheeler, and Yoshioka has extended the range of the Center's collaborative partnerships to include additional New York City social service agencies, a range of schools of social work across the U.S., populations in Los Angeles, and even to collaborators as distant as Japan. Center activities involving partnerships with international, national, and state agencies are also described in this issue.

The studies span a wide range of populations and problem areas: children and adolescents receiving outpatient mental health services, residential treatment services, school-based counseling services, and services for trauma; women who have suffered from domestic violence, with studies focusing on HIV-positive battered Latino women, Asian immigrant women, and Jewish women; elderly Japanese men and women in need of social support and mental health services; and multicultural competence among social work practitioners and students. Other studies examine service system issues such as the impact of managed care on services and utilization of outcomes measurement.

During 1999, the Center reviewed its past, focused on its current research, and planned for the future. Under the leadership of Dr. Steven P. Schinke, the Professional Advisory Committee engaged in a series of discussions focusing on the Center's future directions. These discussions have been enriched by the participation of Dr. Alan B. Siskind, Dean Ronald A. Feldman, and members of the Center's Professional Advisory Committee and Development Council. The Center has benefited from the perspectives of a wide range of practitioners, administrators, and faculty. The insightful guidance and national perspectives presented by two external consultants, Drs. Enola K. Proctor and Richard H. Price, have been especially helpful. Dr. Proctor is the Frank Bruno Professor of Social Work Research at the George Warren Brown School of Social Work, Washington University. She is also the Director of the Center for Mental Health Services Research, one of the Social Work Research Development Centers funded by the National Institute of Mental Health. Dr. Price is a professor in the Psychology Department of the University of Michigan; Program Director and Senior Research Scientist, Social Environment and Health Program, Survey Research Center, Institute for Social Research; and Director, Michigan Prevention Research Center.

Our consideration of future directions has led to important guidelines. This review has reaffirmed the continued relevance of the Center's core mission, namely, to build upon practice and research partnerships locally, nationally, and internationally so as to advance social work practice knowledge toward increased effectiveness of the human services. The *Practice & Research Journal* is the vehicle for dissemination of the fruits of these partnerships.

International Network of Social Work Research Centers Established

Bridging the gap between practice and research in social work is a global concern. As reported in the last issue of **Practice & Research***, the Center has joined with a network of eight European and American social work research centers to exchange and document experiences in practice-oriented research and to discuss possible joint research projects.*

- Center for the Study of Social Work Practice (CSSWP), Columbia University and JBFCS, New York, NY, USA

- Centre for Evaluation of Social Services, The National Board of Health and Welfare, Stockholm Sweden

- Department of Sociological Studies, Sheffield University, Sheffield, England

- Fin-Soc, STAKES, the National Research and Development Centre for Welfare and Health, Helsinki, Finland

- National Institute for Social Work, London, England

- Social Policy Research Unit, University of York, York, England

- Social Work Research Centre, University of Stirling, Stirling, Scotland

- Verwey-Jonker Instituut, Utrecht, The Netherlands

Social Policy Research Unit

UNIVERSITY OF YORK WORKSHOP

In October 1998, the Center participated in a workshop sponsored by the network and hosted by the Social Policy Research Unit, University of York, York, England. The aim of the workshop, "*Formulating Research Problems in Practitioner-Researcher Relationships,*" was to examine aspects of problem formulation by presenting and discussing completed or on-going studies conducted by the participating centers. This critical phase impacts the destiny of a project by determining its orientation and objectives. A central issue considered was how to make questions raised by practitioners and other stakeholders researchable, as well as how researchers might formulate questions so as to influence practice.

Dr. Edward J. Mullen, the Center's Director, presented a paper, *Problem formulation in practioner & researcher partnerships: A decade of experience at the Center for the Study of Social Work Practice.* This paper examined social work research problem formulation in the context of practitioner and researcher partnerships, drawing from a decade of experience at the Center. The paper described studies conducted at the Center with specific attention to how research problem formulation has been influenced by the university, the agency, and community partners. Dr. Neil Guterman, a faculty affiliate of the Center, also delivered a paper, *The role of research in defining a 'practicable' problem for social work: The case of community violence exposure among children and youths.* This paper was based on data collected from the Odyssey Project (see article in this issue). The paper illustrated how research can shape practice perspectives by presenting findings not previously considered.

At the York University workshop, network participants agreed on the desirability of continuing and strengthening network activities. Accordingly, a second network workshop was scheduled for October 1999 in Stockholm, Sweden.

National Board of Health and Welfare

STOCKHOLM WORKSHOP

In October 1999, representatives from all eight research centers participating in the network convened to examine research utilization in the context of researcher and practitioner partnerships. The workshop was hosted by the Centre for Evaluation of Social Services, the National Board of Health and Welfare, Stockholm, Sweden. The questions considered by workshop participants included:

- How can research be utilized and implemented so as to strengthen social work practice?
- Does a researcher-practitioner partnership facilitate research implementation and the utilization of results?

Dr. Mullen delivered a paper, *Using research instruments in clinical practice: Effects on clinician and client satisfaction, which examined how a computerized assessment instrument affects clinical practice.* While the use of research findings in practice has received considerable attention, few studies have examined how computer-based assessment instruments affect practice. The stress on using research findings in practice is based on the assumption that such use would strengthen the validity of the information used by practitioners as they assess, intervene, and evaluate their practice. Similarly, the use of assessment instruments developed through research and standardized through a computerized protocol should enhance the validity of the information used by practitioners in community outpatient practice. This paper presented initial findings of the C-DISC study, which examined these assumptions (see article in this issue.)

Dr. William F. Bacon, a research scientist at the Center, delivered a paper, *Assessing a researcher-practitioner partnership: A survey of clinicians' use of and attitudes towards research in clinical practice.* The paper presented initial results of a survey of JBFCS professional staff, including psychiatrists, psychologists and social workers, examining use of research and other sources of information in clinical practice. The survey also examined knowledge of and attitudes toward the use of clinical practice guidelines.

To guide the network's future work and publications, a steering committee was appointed, including: Dr. Mullen (CSSWP), Dr. Hazel Qureshi (Social Policy Research Unit, University of York, England), and Dr. Haluk Soydan (Centre for Evaluation of Social Services, the National Board of Health and Welfare, Sweden). The international network will next convene in October 2000 at the Verwey-Jonker Instituut, Utrecht, the Netherlands (tentative). The Utrecht meeting will focus on outcomes measurement, which network members view as a pressing concern in each of the represented countries.

Remembering Virginia Wise Marx and Annaclare van Dalen

We note with sadness the passing of two associates of the Center for the Study of Social Work Practice.

Virginia Wise Marx, a founding member of the Center and of the Development Council, passed away in May 1999. Her vision, leadership, and commitment, from which the Center and so many others benefited, commenced early, when she earned master degrees in both social work and in child psychology and began her longstanding involvement in community affairs. Her support and keen interest in children, mental health, and education had a remarkable impact on the Center's unique role, linking social work research and practice. In recognition of her generous support, the Development Council announced last year the creation of the Virginia and Leonard Marx Publication and Conference Program.

Dr. Annaclare van Dalen, a member of the Center's Professional Advisory Committee and a clinician, teacher, and researcher passed away in December 1998. Extraordinarily successful both as a researcher and a practitioner, she embodied the researcher-practitioner partnership that is at the heart of the Center. Both researchers and practitioners could honestly say that she was "one of us." She enjoyed research and believed in its value, and she was also a talented clinician with an eye always on the issues dear to the practitioner—relevance and practicality. Behind her commitment to both research and practice was her dedication to children in trouble. While the researchers and the practitioners will certainly miss her, it is these children and their parents who have lost the most.

"La Mujer": HIV-positive Battered Latina Women

CLAUDIA L. MORENO, PH.D.

La Mujer is a pilot study exploring the complex relationships between partner abuse and HIV risk behaviors among HIV-positive Latina women. By focusing on socio-cultural factors and coping strategies, this study will contribute to the limited knowledge base of this vulnerable population. This article presents preliminary results.

HIV risk behavior and partner abuse are emerging as intersecting problems that threaten the welfare of inner-city Latino communities. In the last 15 years, dramatic increases in the incidence of both HIV/AIDS and domestic violence among Latina women have occurred. Latina women account for 9% of the female total population (U.S. Census Bureau, 1997). The incidence of HIV/AIDS among Latina women has increased from 7% in 1985 to 21% in 1998 (Centers for Disease Control and Prevention, 1998). In addition, Latina women are over represented (34%) in the reported cases of domestic violence (Bureau of Justice Statistics, 1996).

HIV risk behavior has been linked to partner abuse and violent traumas of all types among poor, urban women (Wingwood and DiClemente, 1997). Similar cultural factors put Latina women at risk both for acquiring HIV and for being victims of domestic violence (Land, 1994; O'Keefe, 1994). The identified cultural factors include stigma towards condom use, traditional gender roles, power differentials, attitudes, beliefs, perceptions, acculturation, immigration status, limited English skills, isolation, sexual customs, discrimination, alcohol or drug use, educational and socio-economic status, and religion (Marin, Tschann, Gomez, & Kegeles, 1993; Torres, 1991).

Findings are scarce regarding the relationships between partner abuse and other sexual risk variables such as bartering for sex, having sex with a risky partner (Gilbert, El-Bassel, Schilling, Catan, & Wada, 1996), and being afraid to negotiate safer sex (Amaro, 1995). Several factors may mediate the associations between partner violence and sexual risk behaviors. One such factor is childhood abuse, which research has shown to be associated with both partner abuse and sexual risk behaviors (Gilbert, El-Bassel, Schilling, & Friedman, 1997).

Aims

This study explores the contexts and relationships linking partner abuse and sexual risk behaviors among Latina women. It has four primary aims. The first aim is to delineate the contextual phenomena underlying the co-occurrence of HIV risk behavior and partner abuse episodes that Latina HIV-positive women have experienced. The contextual domains investigated are elicited from the subjects' personal narratives. The domains are: relationship contexts, normative meanings, values and beliefs, affect and cognition, and event sequences of partner abuse and HIV risk behavior.

The second aim is to describe qualitatively and in-depth the relationships between HIV risk behavior and partner abuse among HIV-positive battered Latina women. The relationships include how physical abuse by a partner and fear of this abuse are related to sexual coercion, being forced to have unprotected sex, and failure to use condoms. Circumstances precipitating episodes of partner abuse are also being studied. These circumstances include the consequences of negotiating condom use, insistence on using condoms, disclosing HIV serostatus, STDs and extra relationship affairs, having a sexual relationship with a risky sexual partner, and exchanging sex for money or drugs.

The third aim is to examine the relationship between history of abuse and: (1) background variables (eg., age, ethnicity, acculturation, immigrant status, limited language proficiency); (2) HIV risk factors (a woman's insistence on using condoms, unprotected sexual acts, number of sexual partners, sex trading, and occurrence and disclosure of STDs); and (3) post traumatic stress disorder and the lasting effects of victimization.

The fourth aim is to generate research questions to study the development of an intervention for HIV-positive Latina women who are living in abusive relationships.

Methods and Findings

Participants for this study were selected from two agencies in the greater New York area, Victims Services and the Hispanic AIDS Forum, chosen because each agency serves a large number of Hispanic women. A sample of twenty women participated in focus groups and in-depth interviews. To qualify, participants were identified by each agency as having experienced some form of abuse (life-threatening, physical, sexual, emotional, or verbal), being of Latino/Hispanic background, HIV-positive, and between the ages of 18 to 55 years of age. After several meetings of researcher and staff at the agencies, participants were recruited by agency staff and by fliers.

Three focus groups held in Spanish and English and in-depth interviews were conducted with 20 Latina women. The initial questions concerned their experiences with HIV/AIDS and with partner abuse. Subsequent individual interviews were conducted with key informants who had participated in the focus groups.

The focus groups and in-depth interviews were audiotaped, transcribed, and then analyzed by two raters to obtain consistency of coding and themes. Using grounded theory approach (Strauss & Corbin, 1990) as a theoretical method, data were analyzed and further questions generated. Research questions were clarified using member checking techniques and the constant comparative method. Once the codes and themes were generated, findings were presented to two groups of participants to elicit responses and obtain feedback on the accuracy of the findings.

Four major themes emerged from an analysis of the data: abuse, vulnerability, living with HIV/AIDS, and belief in 'la suerte'. Abuse included the social context of childhood experiences, family, and abuse by partners. All the women in the study suffered from abuse both during their childhood and adult lives. For many of these women, the abuse created a pattern leading to further deprivation, victimization, and destructive behavior. Some women fell into prostitution and drug abuse as a way to survive financially as well as a way to deal with the scar of the abuse. Women spoke about cultural factors such as gender roles determined by 'Marianismo', which can be broadly defined as the importance of motherhood and of deferring to men; 'Machismo', which can be broadly defined as exaggerated masculinity; and the attitude toward virginity. They also defined the different types of abuse, listing verbal, emotional, physical, and HIV transmission.

Women in the study spoke about the intersection of socio-economic factors and the risk of contracting HIV. The factors raised included being foreigners, poor, uneducated, unemployed and possessing limited English skills. The women also discussed their growing vulnerability as they become increasingly more ill, await their residency, fear deportation and losing basic needs such as food, shelter and, especially medication.

The participants' health status influences their lives by determining the quality of their daily existence. The virus drives their everyday struggles to make ends meet, the quality of their relationships with families and significant others, and to whom they will disclose their status. The virus, in combination with traditional gender roles and undocumented status, creates these relationships. Traditional gender roles are implicated in the women's infection, including their own inability to negotiate safer sex, the traditional role of fidelity, and men's frequent infidelity. Being HIV-positive affects the women's current relationships and their ability to establish new relationships, including finding someone who can help support them.

Suerte means fate. Depending on the context, it can refer to good or bad fate. La suerte connotes powerlessness, a force capable of having a domino effect on a life. The women in the study responded to HIV/AIDS with a fatalistic attitude, seeing it as beyond their control. The women reported that because they did not have suerte from the very beginning, they were destined to lead poor and desperate lives.

The study suggests that HIV/AIDS and partner abuse intersect and many times run parallel in these women's lives. The risks involved in their abuse are the same risks that put them at risk for being infected with HIV. Cultural factors such as 'machismo', 'marianismo', and la suerte provide a frame of reference of risk, but also of possible courses of prevention and intervention with Hispanic women.

The study's principal investigator is Claudia L. Moreno, Ph.D.

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Help-seeking Attitudes among Japanese American Older Adults

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This study is part of a larger research project that addresses the relationship between social support and mental health among Japanese American older adults. Using data collected in Los Angeles, Help-seeking Attitudes among Japanese American Older Adults *examines the socio-cultural variables that are associated with their seeking help for personal care.*

With increasing costs of institutional care, in-home care is viewed as a viable alternative to ensure independent living among frail elderly (Benjamin, 1993). Research is available on the cost-effectiveness of home care services, but there has been little research that reflects the perspectives of elders who seek home care assistance (Applebaum & Phillips, 1990). Moreover, very few studies examine the effects of ethnicity and culture on attitudes towards seeking formal care, i.e., help from non-family members (Noelker et al., 1998).

In traditional Asian cultures, adult children were expected to care for frail parents. Seeking help from non-family members is, therefore, a new concept for many Asian American elders. How do Asian American elders feel about seeking paid help from non-family members? Are they willing to receive help from workers of a different ethnicity or from those who do not speak the same language? Do they want to be cared for by their adult children, or do they prefer to receive care from a non-family member? The purpose of this study was to address these questions among Japanese American older adults.

Because of immigration patterns, Japanese American elders have the highest proportion of U.S.-born elders among Asian Americans. Recent figures indicate that 63% of Japanese American elders are U.S.-born in contrast to 16% of Chinese American elders (Elo, 1997). Investigating Japanese American elders can, therefore, lend potentially useful information on the effects of acculturation among Asian American elders.

According to previous research Japanese American elders have retained cultural values of their country of origin and are comfortable depending on their adult children for care (Kiefer, 1974; Osako, 1979). It is important to note, however, that these studies were conducted over twenty years ago when the Japanese American elderly population was composed primarily of first generation immigrants known as *Issei*, who were born in the late 1800s and early 1900s. Today most *Issei* have passed away, and the majority of the elderly in the Japanese American community are those born in the U.S., known as *Nisei*, or are elders who immigrated to the U.S. after 1965 following changes in the immigration laws. Acculturation has been identified as a predictor for increased service utilization among Asian Americans (McCormick et al., 1996; Yamashiro & Matsuoka, 1997), thus it is likely that those who are more acculturated would be willing to seek help from non-family members.

Methods and Findings

Structured interviews were conducted with a community sample of 131 Japanese American elderly (53 males and 78 females), 60 years of age and over. In addition to basic demographic information, respondents were asked about their health and mental health status, social support, and social network. Attitudes toward help-seeking were measured by asking if the respondents agreed or disagreed to an index of 16 statements pertaining to seeking help for personal care from family and non-family members.

Varimax factor analysis extrapolated three factors from the collected data that consisted of 10 statements (alpha = .79). The three factors were conceptualized as (1) preferences for helper characteristics (alpha = .67); (2) interpersonal concerns toward the helping relationship (alpha = .67); and (3) attitudes towards depending on family members for care (alpha = .62). Preferences toward helper characteristics included willingness to seek help from those who did not speak their language or were of a different ethnicity or sex. Concerns toward the helping relationship included reluctance to seek help because of fear of losing personal control, having to burden the caregiver, and fear of losing privacy. Attitudes toward depending on family members included concerns toward being too dependent or being a burden on family members.

Multiple regression analyses were conducted to examine the effects of the demographic and cultural variables on each of these three factors. Results show that acculturation was associated with all three aspects of help-seeking. Elders with lower levels of acculturation preferred helpers of the same cultural and linguistic background and of the same sex, had concerns about the interpersonal aspects of the helping relationship, and did not feel comfortable towards depending on family members for support. Elders with low income were also reluctant to seek help because of concerns about the helping relationship, and did not want to depend on family members for support.

The results of this study confirm previous studies that identify acculturation as an important predictor for help-seeking. Older adults who are less acculturated are reluctant to seek help from someone of a different ethnic and linguistic background, have more concerns about the helping relationship, and are reluctant to become too dependent or a burden on their family members. Given their language preference, it is understandable that they prefer help from someone who speaks the same language. They are also more at ease with people of the same cultural background, which may make them reluctant to receive help from someone of a different ethnicity. Concerns over the helping relationship may be due to the lack of models in non-kin helping relationships in traditional Asian cultures. Elders may not be used to asserting their needs and negotiating for what they need from the helper. Furthermore, when elders feel that they may not be able to reciprocate for the help they receive, they may be more reluctant to become dependent on their family members. In addition, elders may feel that their children are more acculturated than they are, and do not retain the cultural values of filial obligation. The narrower range of acceptable help for elders who are less acculturated places them at risk for not obtaining necessary services.

Another important finding was the association between low income and concern about the helping relationship, and reluctance to depend on family members for support. Low-income elders may be reluctant to seek help because their services are paid through SSI. They are not able to select and chose the help they want, and they also may feel disempowered in the helping relationship because of their income status. They may also be more reluctant to become dependent on their children, because they have limited resources to share with their adult children. The results of the study indicate that social workers need to be sensitive to socioeconomic factors as well as cultural factors when assisting elders to seek home care.

The study's principal investigator is Tazuko Shibusawa, Ph.D.

This study was conducted with the collaboration of Hisanori Ishikawa, Ph.D., Department of Social Work, Japan Lutheran College; and Yasuko Sakamoto, L.C.S.W, Little Tokyo Service Center, Los Angeles, California.

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Assessment of Multicultural Competence Scales for Social Work Practitioners

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Assessment of Multicultural Competence Scales for Social Work Practitioners is the first step in a comprehensive assessment of multicultural counseling competencies among social work students. It is a multi-site study, with data drawn from a cross-sectional mail survey of masters level social work students from 5 schools of social work, and is designed to assess the appropriateness and validity of two self-report inventories used in counseling psychology. This article presents preliminary results. (For further background information on the study, see Practice and Research, *Spring, 1997.)*

For nearly four decades, social work educators have emphasized the necessity for multiculturally competent practice (Van Soest, 1995). Social work researchers, however, have not adequately documented practitioner levels of multicultural competence and how these levels of cultural competence ultimately affect practice interactions, treatment efficacy, and treatment outcomes (McMahon & Allen-Meares, 1992). The discrepancy between the call for multiculturally competent practice and the lack of documentation is due in part to insufficient development of multicultural competence practice measures.

This study addresses such inadequacies with the development and administration of a multicultural social work practice inventory that assesses behavioral and attitudinal levels of multicultural knowledge, awareness, practitioner-client relationship behaviors, and skills (i.e., KABS). KABS consists of modified items from two multicultural self-report inventories utilized in counseling psychology (i.e., the MCI by Sodowsky, Taffe, Gutkin, & Wise, 1994; and the MCAS-B by Ponterotto, Sanchez, & Magids, 1991).

Data in this preliminary report were drawn from a cross-sectional mail survey of 442 masters level social work students from 5 schools of social work (1 west coast, 1 Midwest, 1 southeast, 1 northeast, and 1 Mid-Atlantic region). A multimethod approach was employed to examine reliabilities, observed interscale correlations, and disattenuated correlations across instruments as indicators of the comparability of the constructs being measured by each scale for social work practice students. There were four main objectives of the study: (1) to review the psychometric properties of the MCI and the MCAS-B for their compatibility and appropriateness for social work practice; (2) to examine the factorial (i.e., construct) validity of each instrument; (3) to examine the dimensional nature of the competency construct across both scales by combining them in a factor analysis; and (4) to examine the criterion-related and convergent validity of the instruments.

Method

PARTICIPANTS

Of the 442 participants, 87% were women and 13% were men. Yearly average household income ranged from $28,000 to $37,999 for the entire sample with 20% of the sample reporting a yearly household income in excess of $80,000. Over three-quarters of the sample were first year MSW students. Thirty-six percent reported previous multicultural training experience. In terms of racial self-identification, 9% of the sample self-identified as Asian/ Pacific Islander, 12% as Black/African American/Carribean, 10% as Latino/a, 66% as White/European American, and 2% as multiracial. The majority of the sample self-identified as mainly heterosexual (91%). Approximately 9% self-identified as gay, lesbian, or bisexual.

MEASURES

In addition to basic background characteristics, questionnaire items focused on multicultural competencies (i.e., KABS) and levels of sensitivity to discriminatory attitudes.

Multicultural Counseling Competencies. The two measures used to assess multicultural counseling competencies were the MCI and the MCAS-B.

The MCI (Sodowsky et al., 1994) is a multifactor 40 item self-report measure of multicultural counseling competencies. Participants were asked to indicate "how accurately each statement describes you when working in a multicultural counseling [replaced with social work practice] situation." Each item was scored using a 4-point scale ranging from very inaccurate (1) to very accurate (4). The MCI consists of four subscales: knowledge (11 items), awareness (10 items), relationship behaviors (8 items), and skills (11 items). The subscales have demonstrated moderate to high reliability in the present sample, ranging from .65 for the awareness subscale to .85 for the skills subscale. The MCI items tend to be more behavioral than attitudinal.

The MCAS-B (Ponterotto et al., 1994) is a multifactor 45 item self-report measure of multicultural counseling competencies. Participants were asked to rate the "truth of each item as it applies" to them on a 7-point scale ranging from not at all true (1) to totally true (7). The scale consists of three subscales: knowledge/skills scale (28 items), awareness scale (14 items), and a social desirability cluster (3 items). The awareness and knowledge/skills scales demonstrated adequate internal consistency in the present sample (alpha = .72 and alpha = .87, respectively). Previous research raised face validity concerns regarding the combination of knowledge and skills into a single scale (Pope-Davis & Dings, 1995). The high correlations with the awareness scale suggest that there may be only one dimension of multicultural competence being measured, despite previous factor analytic studies that suggest there might be two dimensions. Ponterotto et al. (1996) stated that the scales need to be interpreted with caution until further rigorous testing is employed. In contrast to the MCI, the MCAS-B items tend to be more attitudinal than behavioral.

Discriminatory Attitudes. The Quick Discrimination Index (QDI; Ponterotto, Burkard, et al., 1995) is a 30-item Likert-type self-report inventory of gender and racial attitudes and general sensitivity to discriminatory attitudes. The total score for the QDI measures "overall sensitivity, awareness, and receptivity to cultural diversity and gender equality." Participants were asked to rate their level of agreement from strongly disagree (1) to strongly agree (5) in response to items such as "I feel ok about my son or daughter dating someone from a different race," or "I think that it is (or would be) important for my children to attend schools that are racially mixed." Internal consistency in the present sample was high (alpha = .87).

Procedure

This study constituted the first step in a comprehensive assessment of multicultural counseling competencies among social work students. The five schools of social work were contacted and asked to distribute the self-administered surveys to their entire first year MSW class within the first 2 weeks of their first semester (the second year class was also given the survey at one site). The study's title "Multicultural Training Project Survey" and eligibility criteria (enrolled in MSW program) were clearly printed on the top page of the questionnaire. The introduction invited voluntary participation and respondents were not remunerated for participation in the study. Completion of the survey took approximately 45 minutes. The response rates for the schools ranged from 18% to 63%.

Results

THE MCI AND MCAS-B: SOCIAL WORKERS COMPARED WITH PSYCHOLOGY INTERNS

Figure1. Social Work and Psychology Student Mean Scores on the MCI
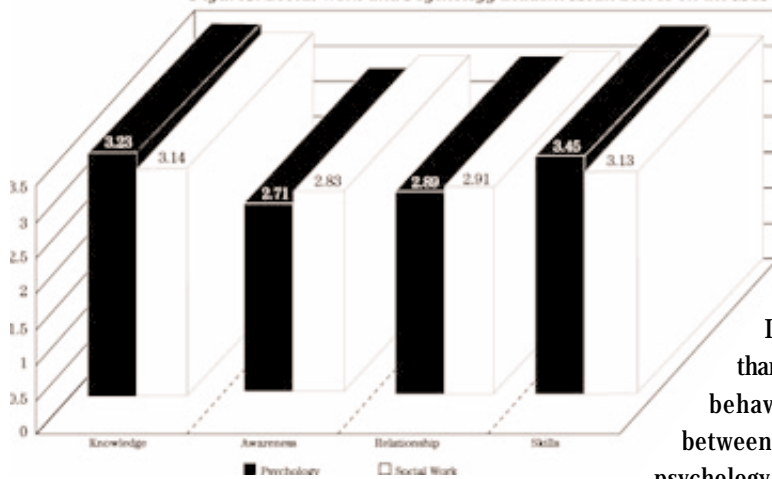
In examining the mean levels of multicultural competence across the MCI measure for all subscales (see Figure 1), social work student scores in the present sample were comparable with psychology graduate student intern scores in another study (data extracted from the Pope-Davis & Dings, 1994). Psychology students had slightly higher knowledge and skill scale scores, which is not surprising since they were already in field internships when they participated in the Pope-Davis & Dings (1994) study, and, as a result, most likely had a few years of clinical classroom preparation already. Interestingly, social work students' mean scores were slightly higher than psychology interns with respect to self-awareness and relationship behaviors. In contrast, however, in a comparison of the mean scores between social work students and psychology students on the MCAS-B, the psychology interns tend to score considerably higher for both knowledge/skills (mean = 131.8 vs. 102.9) and awareness subscales (mean = 86.4 vs. 75.1).

CONSTRUCT VALIDITY OF THE MCI AND MCAS-B

Within each instrument and across scales, we examined interscale correlations and inter-correlations. The observed interscale correlations within each instrument were fairly comparable to those obtained in previous studies, suggesting that each instrument is not performing in an unusual manner for social work students. Overall, the intercorrelations between the instruments (see Table 1) also suggest that there are only a few problems with the scales. Specifically, the correlation for MCI knowledge with the MCAS-B knowledge/skills subscale was fairly strong (r = .52), as was the correlation between the MCAS-B knowledge/skills with MCI skill (r = .51). The correlation, however, between the MCAS-B awareness and MCI awareness was quite low (r = .04), suggesting that these two constructs might not be capturing the same phenomenon.

Factorial validity. Factor analysis was used in this study for two purposes: (1) to establish the factor structure of the MCI, MCAS-B, and the combination of MCI-MCAS-B among social work students; and (2) to establish empirically the construct validity for the competency constructs (i.e., KABS) among social workers. A principal components analysis using varimax rotation on all factors was performed and

resulted in a 4-factor solution for the MCI, a 5-factor solution for MCAS-B, and a 4-factor solution for the combined scale. Examination of the scree tests confirmed the factor solutions. The 4-factor extraction for the MCI (n = 279) accounted for 23% of the common variance and resulted in factor loadings and eigenvalues as follows: Skills (.46-.73; eigen = 8.99); Knowledge (.43-.67; eigen = 2.73); Awareness (.41-.70; eigen = 2.32); and Relationship Behavior (.46-.63; eigen = 1.99). Interestingly, the MCAS-B (n = 351) revealed five factors in contrast to the anticipated two factors. The 5-factor extraction for the MCAS-B accounted for 19% of the common variance with the following factor loadings: Skills/Knowledge items (.38-.74; eigen = 8.3); Multicultural Readings/Concepts (.65-.80; eigen = 4.6); Social/History (.41-.70; eigen = 3.02); Discrimination (.27-.70; eigen = 1.80); and Awareness (.42-.66; eigen = 1.5). The 4-factor extraction for the combined MCAS-MCI scale (n = 241) produced a 4-factor solution that accounted for 18% of the common variance. The factor loadings were as follows: Knowledge (.35-.72; eigen = 14.47); Skills (.31-.68; eigen = 5.42); Awareness (.34-.71; eigen = 4.09); Relationship (.32-.67; eigen = 3.51). Discussion of the 5-factor structure is beyond the scope of this report as is the combined scale analysis. We will, however, be analyzing these findings in future analyses.

In selecting the best factor structure for social work students, our primary criteria were the interpretability and clarity of each factor in the final factor loadings. Using this as a guideline, it is clear that the 4-factor structure and constructs found in the MCI (i.e., KABS) is the model best represented in our data, a conclusion confirmed by combined scale factor analysis. The factor analytic solution reflected the anticipated item groupings; thus, the MCI provides preliminary evidence of the multicultural counseling construct's (i.e., KABS) applicability to social work students.

Using the Group-Difference approach to assessing criterion-related validity (Walsh & Betz, 1990), we examined the MCI score differences between those who had previous multicultural training and those who had none. For clarity in interpretation, we included only first year MSW students (n = 339). Analyses of the previous training variable were mixed: the "trained" sample scored significantly higher than the comparison group on two of the MCI subscales. Specifically, students who had previous multicultural training scored significantly higher than students who had no previous training in terms of multicultural competency skills (mean = 3.19 vs. mean = 3.04), t(239) = 2.33, p < .05, and awareness (mean = 3.04 vs. mean = 2.73), t(239) = 2.65, p < .05 . There were no significant differences in training level by multicultural knowledge or relationship competencies.

We also wanted to examine if the subscales of the MCI were appropriately correlated with similar but distinct constructs. For example, if the participants' scores on competency were strongly correlated with their scores on a measure of sensitivity to discrimination (e.g., QDI), this would provide more evidence that the multicultural competency subscales had construct validity. We chose the QDI and again used only first year students. Results indicated that competency knowledge (r = .32, p < .000); awareness (r = .34, p < .000); and skill (r = .24, p <.00) were all moderately positively correlated with sensitivity to discrimination, providing further evidence of construct validity for the knowledge, awareness, and skill competency constructs among social work students.

Table 1. Intercorrelations and Reliabilities for the MCAS-B and MCI.

	Know ⬭	Aware ⬭	Know	Aware	Skills	Relate
Know ⬭	α = .90					
Aware ⬭	.38	α = .70				
Know	**.52**	.22	α = .80			
Aware	.43	**.04**	.45	α= .65		
Skills	**.51**	.09	.61	.40	α = .84	
Relate	.26	-.02	.25	**.28**	.23	α = .73

Note: ⬭ indicates this is a MCAS-B scale; all others are the MCI. Cronbach Alphas are along the diagonal.

Conclusion

The psychometric properties of the MCI and the MCAS-B appear fairly strong for both instruments. Internal consistency was moderate to high across all subscales. Preliminary factor analyses suggest that the MCI as a competency measure might be applicable to social work practice. Moreover, analyses provided evidence for the factorial, criterion, and convergent validity of the dimensional nature of the competency constructs (i.e., KABS). The results are preliminary and should be interpreted with caution until further analyses support these findings. Despite the preliminary nature of the findings, they appear to support using the MCI as a measure of multicultural practice competencies in social work training as well as practice. Future development of social work-specific multicultural practice instruments should incorporate the multicultural competency KABS constructs. The discrepancy between the call for multiculturally competent practice and the lack of documentation is due, in part, to insufficient development of multicultural competence practice measures.

The study's principal investigators are Karina L. Walters, Ph.D. and Darrell P. Wheeler, Ph.D., M.P.H.

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Domestic Violence and Asian Immigrant Women

MARIANNE R. YOSHIOKA, PH.D.

Domestic Violence and Asian Immigrant Women is a descriptive study focusing on attitudes toward and associated psychosocial factors of partner abuse among the diverse Asian immigrant community. From the collected sample, the Revised Attitudes toward Wife Abuse Scale (RAWA) was developed. This article presents initial findings of this research.

During the last decade partner abuse has emerged as a prominent issue in Asian immigrant communities in the United States. Since 1985, 10 different South Asian community organizations in the New York City area alone have developed programs to address the problem of partner violence in their communities. The New York Asian Women's Center, a New York City domestic violence agency focusing specifically on East Asian women, reported approximately 3,000 inquiries for service during 1996, up from approximately 2,000 in 1990. This increase indicates a growing recognition that domestic violence is a problem within Asian American communities.

Asians are one of the fastest growing immigrant groups in the United States. From 1980 to 1990 the number of Chinese, Koreans, and South Asians in the New York City area increased by 105%, 216%, and 103%, respectively (City of New York, 1995). In the social science and social work literatures, however, information regarding community attitudes towards domestic violence as well as the cultural context of service for battered women from these communities is virtually absent.

The limited research available suggests that a complex interweaving of cultural, environmental, and interpersonal factors contribute to risk for violence among immigrant families. Traditional Asian values of privacy, honor, self-restraint, harmony, and order (Hofstede, 1984; Hu & Chen, 1999; Kirkbride, Tang, & Westwood, 1991; McLaughlin & Braun, 1998) may encourage minimization and hiding of serious family problems (Ho, 1990). Also, recent immigrants lack the natural informal support networks customary in their native countries and are often unfamiliar with the organization and function of American social service systems. The resulting isolation can be compounded by a limited command of English (Das Dasgupta & Warrier, 1996).

Each of these factors contributes to understanding the circumstances of battered Asian women. Empirical research is needed to provide information necessary for the design of culturally competent domestic violence and batterer related services, and for training professionals working with Asian women living with violence.

The study described in this article was designed to address these needs. The study had three aims: (1) to describe attitudes of the diverse Asian immigrant community toward partner abuse; (2) to identify correlates of these attitudes; and (3) to identify psycho-social factors associated with abuse among Asian immigrant families.
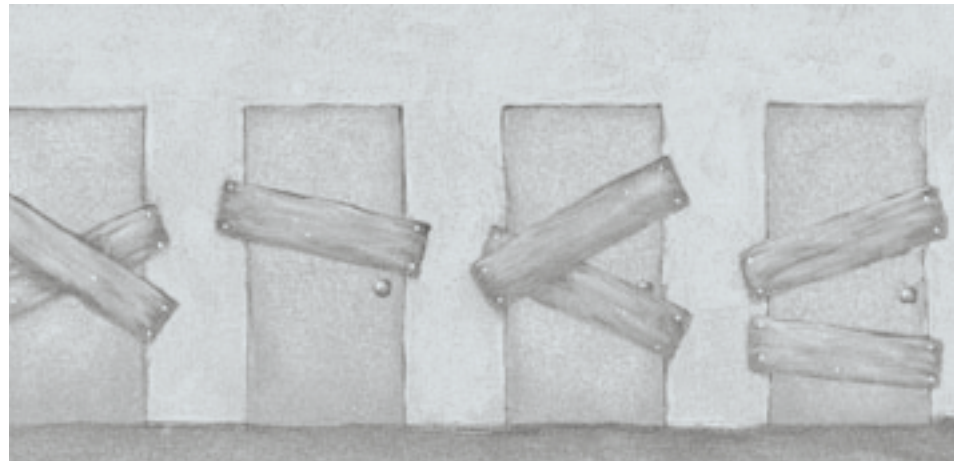
Methods and Findings

Investigators have completed attitudinal surveys of 650 Chinese, Cambodian, Korean, Vietnamese, and South Asian adults. Analysis of the responses of the Chinese and Cambodian samples is complete. Inter-group differences of pro-violence beliefs have been examined and analysis of the responses of the other ethnic groups is underway. In addition, the investigators have completed revision of an existing measure of wife abuse attitudes.

Based on the sample of Chinese and Cambodian adults, the Revised Attitudes toward Wife Abuse Scale (RAWA) was developed (Yoshioka & DiNoia, 1999a). Originally developed by Briere (1987), the revised scale measures attitudes toward domestic violence in three related dimensions: situation-specific approval of violence; endorsement of male privilege; and perceived alternatives to abuse. For clinicians who work with battered women or batterers, the RAWA is a useful tool to assess attitudes toward violence in each of these dimensions. It provides social workers with a simple, easily scored, and reliable measure for assessment and intervention planning. The ability of the measure to detect ethnic differences suggests its utility in clinical settings, as a tool for identifying culturally relevant areas of risk, and for developing culturally sensitive intervention strategies.

Analyses of these attitudes found significant gender and cultural differences (Yoshioka & DiNoia, 1999b). A regression analysis found that gender, ethnicity, and witnessing parental domestic violence were significant predictors of attitudinal responses. Gender was a consistent predictor of each of the sub-scale scores. In each case, men endorsed attitudes more favorable toward wife abuse. Ethnicity was found to be predictive of attitudes of male privilege and perceptions of lack of alternatives available to women living with violence. In both cases, Cambodians scored higher than Chinese. Finally, witnessing a parent being hit by a partner predicted both approval of violence in specific situations and attitudes of male violence. Despite the fact that Asians are considered as one monolithic group, these analyses clearly demonstrate inter-group differences in attitudes toward wife abuse.

Additional objectives of this research have been to describe the health, employment, and family circumstances of battered Asian immigrant women, and to identify significant correlates of wife abuse. To date, in-depth interviews have been conducted with 15 battered Chinese immigrant women.

Additional interviews are being conducted. Due to the investigators respect for the importance of privacy in this community, data collection is proceeding slowly. Preliminary analysis suggests that the overwhelming majority of women is under-employed in low paying jobs and sees few alternatives to living with violence.

Despite significant cultural barriers encountered in conducting this research, the investigators are dedicated to understanding the circumstances of these battered women and identifying ways by which they may be better served.

The study's principal investigator is Marianne R. Yoshioka, Ph.D.

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Domestic Violence and Jewish Women

ELLEN R. DEVOE, PH.D.; GRETCHEN BORGES, M.S.

Domestic Violence and Jewish Women *is designed to examine the correlations among religious identifications, beliefs and traditions and responses to domestic violence by several distinct populations of Jewish women who have sought help for domestic violence.*

Violence against women by their intimate partners is a leading cause of injury and death. In a national study, 28% of married couples reported at least one episode of physical violence over the course of their relationship (Straus & Gelles, 1986). It is estimated that 10% to 14% of all married women have been raped by their husband, but the proportion of battered women who have experienced marital rape rises to 33-50% (Finklhor & Yllo, 1987; Russel, 1983). One third of all female homicide victims are killed by their husbands or boyfriends (U.S. Dept. of Justice, 1992).

Despite the severity of partner violence across all ethnic groups and classes, the manner in which religious and cultural traditions and biases influence women's experience of domestic violence has not been studied systematically. Cultural background influences how women define physical, emotional, sexual, and economic abuse, how they react to abuse, why they stay in abusive relationships, and what systems of support are helpful to cope with domestic violence (McGee 1997; Fischbach & Herbert, 1997). An understanding of these cultural influences is critical to providing intervention at any level.

Extensive evidence suggests that the incidence and prevalence of domestic violence in the Jewish community is similar to the rate in other communities (Spiegel, 1997). An estimate by the organization Jewish Women International indicates that 15 to 25% of all Jewish households experience domestic violence. This rate is the same among Orthodox, Conservative, and Reform Jews (Giller & Goldsmith, 1980). Even families who have looser ties to the Jewish community are often influenced by Jewish cultural background (Schlossberger & Hecker, 1998). The community's concern about domestic violence is demonstrated by extensive coverage of the problem in both popular and academic literature, organizational responses, (e.g., Jewish Women International Organization), and web pages (e.g., The Jewish Domestic Abuse and Agunah Problem (http://members.aol.com/Agunah/). Despite the statistics and the acknowledgment that culturally specific education and intervention programs for domestic violence are more successful than generic programs, the special issues of Jewish women have not been comprehensively studied.

Aims

Front line domestic violence practitioners need specific knowledge to identify and screen battered women (Harwell, 1998), but little is known about practitioners' level of awareness regarding client cultural values and religious beliefs (Fischbach & Herbert; McGee; Schlossberger & Hecker). The knowledge base of practitioners' perceptions of barriers to providing services to Jewish women survivors is limited. At all levels of service, training priorities need to be identified (Short, Johnson, & Osattin, 1998) in order to understand how practitioners might be better supported in serving Jewish women who have experienced domestic violence.

The hypotheses being considered in this study are: (1) Jewish women will have special issues relating to the Jewish tradition and cultural biases that influence their beliefs concerning domestic violence; (2) their traditions and cultural biases will influence Jewish women's responses to domestic violence; and (3) the presence or absence of social and family support systems will influence Jewish women's responses to domestic violence.

Methods

The study involves two components: (1) focus groups for Jewish women who have experienced partner abuse and for 10 UJA-Federation agency-affiliated clinicians who work with Jewish battered women, and (2) individual in-depth interviews with the women. Thirty-six Jewish women who have experienced domestic violence or partner abuse will comprise the primary sample. Three unique sub-groups of women (12 each) will be targeted for the study: secular or Reform Jewish women; Orthodox Jewish women; and Jewish women from the Russian immigrant community. The subjects will be recruited through several agencies serving battered women. These agencies will be affiliated with UJA-Federation, Jewish Board of Family and Children's Services (JBFCS), and Federation of Employment Guidance Services Long Island Division (FEGS) and will be identified and contacted by UJA.

Focus groups will be held in community agencies where the women have sought services. Each focus group will be audiotaped, with subjects' informed consent, for later transcription and review. The focus groups are designed to increase understanding of the unique issues facing three subgroups of Jewish battered women. Topics addressed will include: religious and cultural aspects of women's experiences, beliefs, and definitions of partner violence; religious and cultural influences on women's decisions about their relationships; family and personal considerations in women's decision-making about their relationships; women's help-seeking and experiences of support within informal networks; and Jewish battered women's perceptions of effective strategies for the provision of support and assistance within their families and communities.

A semi-structured interview protocol, reflecting critical dimensions of the experience of partner violence, and the interplay among religious and cultural issues and partner violence will be administered to the 36 women who participated in focus groups. Audiotapes of the focus groups will be transcribed and a qualitative analysis of the transcripts and the moderators' notes on individual sessions will be conducted.

At the conclusion of the study, the investigators will produce a research report of the findings and a proposal for external funding for a more rigorous study. The heterogeneity of experiences among participants will lead to some difficulty in controlling for other factors. It is anticipated that women from different subcultures (Reform, Orthodox, Hasidic, émigrés, etc.) will be influenced in different ways by the Jewish tradition and cultural biases. This pilot study will be unable to address these differences. Using the data collected in this pilot study to identify issues of central concern, a proposal for a larger study will be designed to identify the different responses of women coming from different subcultures of the Jewish

tradition. The data collected in this larger study could contribute significantly to the development of culturally specific domestic violence programs targeting education, prevention, and interventions.

The study's principal investigator is Ellen R. DeVoe, Ph.D. Co-investigators are Kathryn Conroy, D.S.W. and Gretchen Borges, M.S. Collaborating investigators are Anita Altman, Founder, UJA-Federation Task Force on Family Violence and Evelyn Roth, Chair, UJA-Federation Task Force on Family Violence.

The funding for the study was raised by UJA.

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The Odyssey Project and Community Violence Exposure among Children and Youth Living in Residential Treatment Settings

NEIL B. GUTERMAN, PH.D.

The Odyssey Project is a multi-year national study following children in their journeys through residential treatment settings. This study was described in detail in a previous issue of Practice and Research (Guterman, 1997). This article summarizes the study and describes recent progress.

The Odyssey Project is the first national descriptive and longitudinal study examining the psychosocial characteristics and outcomes of children served in residential treatment settings. Earlier studies have documented the demographic characteristics of children in residential placements (Dore, Young, & Pappenfort, 1984; Pappenfort, Young, & Marlow, 1983; Pappenfort, Kilpatrick, & Roberts, 1973), factors in the post-discharge environment that appear to be associated with positive outcomes (e.g., Wells, 1991; Guterman, Hodges, Blythe, & Bronson, 1989), and ecologically-based factors in a child's life that shape the course of residential treatment and its impact on the resident (Whittaker & Pfeiffer, 1995; Guterman & Blythe, 1986). Lacking, however, is fundamental knowledge about the psychosocial characteristics of children and youth entering residential treatment in the U. S., their experiences prior to entry into residential care, and the services and supports they receive in residence linked with positive outcomes. In response to the pressing need to develop a more comprehensive empirical base undergirding residential care in the U. S., the Child Welfare League of America has enlisted two dozen residential treatment and group home facilities into the Odyssey Project study, with an expected subject enrollment of approximately 2,200 children and youth across the country.

Under the auspices of the Center for the Study of Social Work Practice, three agencies of the Jewish Board of Family and Children's Services (JBFCS) form sites for the local study: Hawthorne Cedar-Knolls Residential Treatment Center, Linden Hill School, and the Jerome M. Goldsmith Center for Adolescent Treatment. These three sites have enrolled an ethnically diverse sample of 169 children and youths, representing 66% of those eligible. The descriptive phase data collection has been completed at these sites and presently longitudinal data collection continues to follow the youngsters as they journey through residence and after discharge.

At the three JBFCS sites, Center researchers have focused their interests on children's experiences in their home communities, and most particularly on their experiences of community-based violence. Familial factors have long been considered important in the functioning of children served within such clinical settings, yet less focus has traditionally centered on the importance of children's experiences outside the family. Indeed, Odyssey Project Center researchers have reported in initial findings from the study that although clinicians report substantive knowledge of youngsters' exposure to violence in the home, they appear to be less knowledgeable about a wide variety of community violence experiences, including the most lethal forms (Guterman & Cameron, 1999). Such findings suggest new horizons for clinical assessment, given that community violence exposure has been

linked with a host of psychosocial sequelae similar to those found in cases of family violence, and given that such experiences are by all measures more commonly reported than family victimization experiences. Indeed, because of recent high profile tragedies touching the general public like those that occurred at Columbine High School and at a Los Angeles Jewish community center last summer, media sources such as *Newsweek*, *New York Newsday* and the *Family Therapy Networker* have drawn from the Center's local Odyssey Project's findings in interpreting events for the broader public.

Sequelae found linked with community violence experiences in youngsters have included: symptoms of post-traumatic stress disorder (Berman, Kurtines, Silverman, & Serafini, 1996; Fitzpatrick & Boldizar, 1993; Horowitz, Weine, & Jekel, 1995), heightened risk for depression (Freeman, Mokros, & Poznanski, 1993; Gorman-Smith & Tolan, 1998), cognitive and academic delays (Osofsky, Wewers, Hamn, & Fick, 1993; Shakoor & Chalmers, 1991), and increased aggression (Attar, Guerra, & Tolan, 1994; Cooley-Quille, Turner, & Beidel, 1995; DuRant, Pendergrast, & Cadenhead, 1994). While researchers have struggled to adequately conceptualize and operationally define community violence exposure (Guterman & Cameron, in press), clinicians must strive to effectively address victimization experiences when they occur inside or outside the home. To respond to clinical needs, Center Odyssey Project researchers have designed, developed and disseminated a clinical assessment framework, derived from qualitative interviews with study participants (Guterman & Cameron, 1997), aiding therapists in their assessment of young clients' community violence exposure.

Our understanding of the impact of community violence on youngsters served within clinical settings is limited because the vast majority of empirical studies on this problem have been conducted with non-clinical samples. Given this, the Center's Odyssey Project research team is presently examining how community violence experiences may differ in a clinical sample of youngsters living away from their home communities and what role these experiences may play in their presenting clinical profiles (Guterman, Cameron, & Hahm, 2000). Such findings should make an important contribution to our understanding of the role of community violence experiences not only in youngsters placed within residential treatment settings, but also in clients seen in a broad variety of clinical settings.

The study's principal investigator (local CSSWP site) is Neil B. Guterman, Ph.D.

Bruce Grellong, Ph.D. is co-investigator. Mark Cameron, M.S., Peter Tolk, M.S. and Hye-Ouk Hahm, M.S. are research assistants. The principal investigator for the national multi-site study is Patrick Curtis, Ph.D. (CWLA). Cynthia Papa-Letini, Ph.D. (Berkshire Farm Center for Children and Youth) and Gina Alexander, M.S.W. (The Villages of Indiana) are co-principal investigators for the national multi-site study.

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From Research to Practice:
The C-DISC in Clinical Services

WILLIAM F. BACON, PH.D.

The C-DISC in Clinical Services *is a multi-year, NIMH-funded study examining the impact of introducing a standardized, computerized assessment procedure into the intake process of community-based mental health clinics. The study has been described in considerable detail in previous issues of the Center's journal* Practice & Research *(Fisher & Jackson, 1994; Bacon, 1997). This article summarizes the study and describes some analyses that are underway.*

The Computerized Diagnostic Interview Schedule for Children (C-DISC) was developed in recent years by the National Institute of Mental Health and has already proven its usefulness for research purposes. It is a reliable, valid, and inexpensive means of identifying psychiatric disorders and psychological symptoms in children and adolescents (Shaffer et al., 1993; Piacentini et al., 1993). The present study was designed to determine whether the C-DISC can be of value in clinical services. It involves introducing the instrument into the child-client intake process at a number of Madeleine Borg Community Services (MBCS) outpatient mental health clinics of the Jewish Board of Family and Children's Services (JBFCS). Seven MBCS clinics, located in four of the five boroughs of New York City, participated in at least one of the study's phases.

To test the value of the C-DISC in clinical services, the instrument was administered to a sample of children and their caretakers prior to their being seen for initial intake interviews by a JBFCS clinician. For each participating client, a computer-generated C-DISC report, including probable and possible diagnoses and endorsed symptoms, was presented to the intake clinician before the first scheduled meeting with the child and caretaker. The chief question of the study is whether clinicians' diagnostic practices or treatment recommendations are influenced by the availability of the C-DISC reports. The study also examines clinicians' subjective impressions of whether the reports are helpful and useful, and whether the clients' satisfaction with the intake process is affected by the addition of a C-DISC interview.

Data collection began with a prospective baseline phase in order to gather information on diagnostic and treatment practices of the participating clinicians prior to the introduction of the C-DISC. This phase of the study ran from September 1995 to August 1997 and included various changes in the experimental design and procedures in response to challenges faced in implementing the study. In all, data were collected during the prospective baseline phase on 142 child intake cases seen by 52 clinicians.
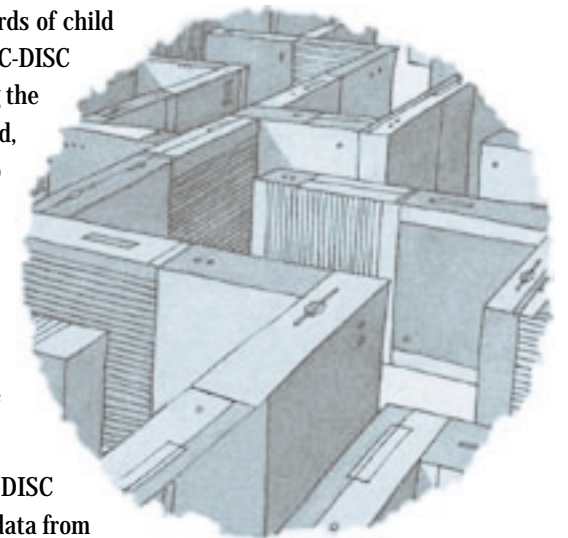
The experimental phase of the study began in December 1997 and was completed in June 1999. Twenty-two clinicians in four MBCS clinics participated in the experimental phase. Study staff conducted 194 interviews (97 children and 97 caretakers) prior to intakes with participating clinicians. For each case, information was also collected from the children, caretakers, and clinicians at the conclusion of the intake visit. Children and caretakers reported on the client's symptoms and their satisfaction with the intake process; clinicians provided information about symptoms, diagnoses, and treatment recommendations for the client. Similar information was also collected on 96 control cases—children and caretakers who underwent the standard intake procedure without the addition of a C-DISC interview.

The study is currently in the final stages of data collection. C-DISC staff are in the process of collecting retrospective baseline data — examining case records of child intakes seen by participating clinicians before their first participation in the C-DISC study. These data will show whether clinician diagnostic practices (during the prospective baseline phase) changed as a mere result of being observed, which will help clarify inferences about which effects are attributable to the introduction of the C-DISC. Data analysis will begin when data collection is completed, which is expected to be in the spring of 2000. The majority of the study hypotheses are to be tested using a mixed model nested-factorial design (method nested within clinicians and then within clinic) in which the assessment method (C-DISC or checklist) is treated as a fixed effect and the clinics and clinicians are treated as random effects.

Along with the core hypotheses concerning the effects of the C-DISC on diagnostic practices and on satisfaction with the intake appointment, data from the study may be used to examine a number of other research questions. For example, after indicating their level of satisfaction with their intake appointment on the post-intake checklist, clients, caretakers and clinicians also provided open-ended descriptions of the basic problem requiring clinical attention. Once these statements are appropriately coded and categorized, it will be possible to examine the concordance between problems as described by parents, caretakers and clinicians, and also to examine whether the C-DISC interview changed how clinical problems were conceptualized by any of the parties.

The data set on diagnoses as assigned by the C-DISC and by the clinician is also very rich and may yield a number of interesting findings. For example, how frequently do clinicians disregard or reject the diagnoses suggested by the C-DISC? How does client satisfaction vary with diagnosis or with concordance between clinician and C-DISC diagnosis? C-DISC staff at the Center and at the New York State Psychiatric Institute will be pursuing answers to these and many other questions in the coming months.

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A Proposal for Outcome Measures: Service Effectiveness Research Group

DAVID T. MENEFEE, PH.D.

The Service Effectiveness Research Group (SERG), is a unit under development within the Center for the Study of Social Work Practice. Its mission is to provide consultation to human service organizations in assessment, development, installation, and/or evaluation of outcome-based management (OMB) systems.

Over the past two decades there has been a growing emphasis on outcomes measurement in the human services industry (Mullen & Magnabosco, 1997). Two forces have contributed to this phenomenon: an increase in the general public's demand for accountability, and an increase in the academic and practice communities' need for legitimization (Martin & Kettner, 1996). The underlying question driving both forces is, "Are services effective?" (Patti, 1987). Practitioners say, without hesitation, "Yes, of course!" academicians say, "It depends", and the public says, "Show me!" Why does such an important question get such disparate answers?

The question is a complicated one and is due to the unique nature of the work itself. The outcomes of social programs are vague and ambiguous. The practice theories, methods, and the tools practitioners use are numerous and equally vague. The resources used in the provision of services are more often than not severely limited. Finally, a multitude of other factors, not within the control of the therapeutic relationship, often affects program outcomes. For all of these reasons, the challenge of assessing the independent effects of services on client outcomes is formidable indeed.

Outcome measures inform the effectiveness and efficiency of social programs (Martin & Kettner). Effectiveness indicates to what degree a desired effect is produced. It is a measure of quality in relation to output. For example, in the case of a homeless prevention program, one measure of effectiveness might be the number of households that remain stable divided by the total number of households served. Efficiency indicates how well resources are being used. It is a measure of cost in relation to output. Using the same example, one measure of efficiency might be the full cost per household served. To determine if a program is cost-effective, it is necessary to have multiple measures of program efficiency and effectiveness and to measure these outcomes over time until trends are established (Boardman, Greenberg, Vining, & Weimer, 1996). Once trends are established and performance is assessed, the work unit can set difficult but achievable (stretch) goals for each measure. In addition, the unit can construct an overall index summarizing the extent of goal achievement for efficiency and effectiveness. Ultimately, these outcome measures tell the program how successful it is in providing the services described in its mission statement.

Factors that are external to the program may influence program outcomes as well. Factors such as program priorities, structures, policies, culture, size, and staff must be taken into consideration in measuring the effects of services on outcomes. This aspect of the model is no less important than the other components in the development of a comprehensive outcome evaluation system.

Program outcomes, whether positive or negative, can only be understood and explained within the context of resources, activities, and environmental factors. In fact, reporting on outcomes alone could provide a very misleading picture of the effectiveness and efficiency of services. A more complete evaluation of program effectiveness and efficiency would include an account of "resources consumed", "services rendered", and "outcomes achieved".

Currently, comprehensive outcome measurement systems are being implemented in human service organizations across the country. Legislative mandates for outcome measures, the threat of privatization, increased competition for resources, the emergence of managed care, and a growing demand for services are forcing these organizations to be more accountable to their stakeholders (Menefee, 1997).

The Service Effectiveness Research Group

The Service Effectiveness Research Group (SERG), a unit within the Center for the Study of Social Work Practice (CSSWP), provides consultation to human service organizations in assessment, development, installation, and/or evaluation of outcome-based management (OMB) systems. Working with top, middle, and supervisory management, SERG will: (1) analyze the readiness of an agency or program to employ outcome measurement systems; (2) assess and develop the capacity of managers to use outcome measurement systems; (3) assist managers with constructing management and/or clinical outcome measures; (4) collaborate in planning and implementing outcome measurement systems; (5) collect, store, analyze, and report outcome data informing agency performance; and (6) evaluate the efficacy of outcome measures and management systems for improving agency performance.

ORGANIZATIONAL ANALYSIS

SERG assesses an organization's readiness for implementing outcome-based management. By analyzing the structures, processes, and conditions within the organization, SERG determines the degree to which current organizational arrangements will support outcome-based management. To achieve this determination, SERG performs a comprehensive assessment of organizational values and culture, management philosophy and practice, strategic goals and objectives, agency structures, management information systems, data collection, processing and feedback systems, communication patterns, and level of resistance to change. This assessment is reviewed with agency management, along with recommendations for preparing the organization to receive outcome-based management.

MANAGEMENT ASSESSMENT

Using both qualitative and quantitative research methods, SERG assesses the management team's ability to effectively participate in, implement, and use outcome-based management systems. SERG examines the manager's knowledge of management control systems as well as his/her capacity to successfully apply these principles. SERG evaluates the manager's ability to develop and use valid critical/management indicators for measuring effectiveness, efficiency, and financial viability. The manager's ability to construct and use reliable and valid data collection instruments, methods, and

tools is assessed, as is the skill level of the manager with respect to data analysis and interpretation. SERG also assesses the manager's capacity to prepare his/her work group to participate effectively in managing the performance of the unit based on continuous feedback from outcome indicators. An overall assessment is presented to the management team for review and a plan for developing management knowledge and skills is recommended. If approved, a management development intervention is designed and implemented.

MEASUREMENT SYSTEMS DEVELOPMENT

SERG assists agencies in evaluating existing or constructing new outcome-based measurement systems that support the information needs of external regulatory bodies as well as internal management staff. We begin by assessing current clinical/management indicators, databases and data collection tools and methods to determine their reliability, validity, and usefulness. Working with management and employees at each level of the organization, SERG develops indicators to measure productivity, capacity utilization, service quality, service effectiveness (including clinical outcomes), client satisfaction, financial status, and other important performance measures. Once appropriate indicators are identified and refined, SERG uses existing data and data collection procedures (where available and valid) to assess program performance. Where data are not available, SERG assists in the design and use of data collection tools and methods that inform remaining performance indicators. SERG also advises agencies in the development of automated information systems that support data collection, data entry, analyses, and report generation. The product of SERG's intervention is a fully functioning and integrated outcomes management system throughout the agency.

OBM SYSTEMS IMPLEMENTATION

As with most major organizational changes, effective installation of OBM systems must be well planned. SERG assists client agencies to plan the installation of its OBM system so as to insure its success and long-term viability. Through information gathered from the organizational analysis, SERG assists management in devising a step-by-step action plan implementing OBM with the least amount of disruption to ongoing operations as possible. Specific objectives, program steps, schedules, accountabilities, and budgets are written so that agency management is fully aware of the resources, activities, and costs involved in successful implementation. SERG also assists management in troubleshooting problems related to the effective installation and ongoing maintenance of OBM systems. In addition, SERG works with managers to help prepare employees for changes that will occur as a result of the OBM intervention, thereby fostering greater acceptance of OBM.
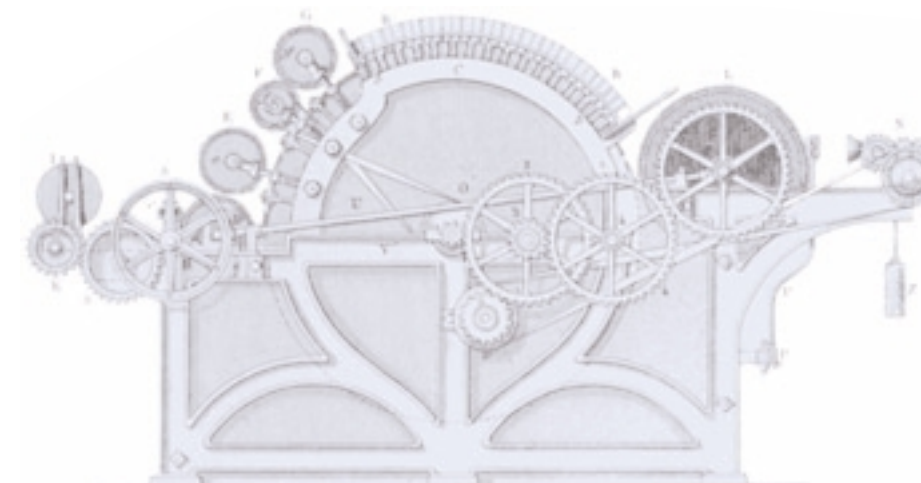
DATA MANAGEMENT, ANALYSIS, AND REPORTING

SERG supports client agencies in the collection, entry, storage, and analysis of information on clinical and management outcomes. SERG associates work with agency management to design data collection procedures, data analysis needs, and report formatting. The most expedient and unobtrusive data collection methods are used; data entry is fully automated using scanners; and data are stored in a dedicated, secure server, and are backed up on a regular basis. Data analyses and report generation are performed and supervised by researchers and statisticians working with CSSWP at Columbia University School of Social Work. Ad hoc and regular monthly reports at the work unit and organizational levels are available. SERG provides assistance to client agencies in the interpretation of reports and in decision making related to work redesign and reengineering to improve performance. In addition, SERG maintains the capacity to compare clinical and management performance across work units and client agencies.

ONGOING SUPPORT OF OBM SYSTEMS

SERG provides online support of outcome measurement systems by building an infrastructure within the agency that supports the active use of data for planning and implementing strategic and tactical changes. This is accomplished through the integration of group decision making and computer software technologies, otherwise known as participatory decision making support systems (PDSS). PDSS is a program evaluation system that provides information on financial, efficiency, and effectiveness outcomes and their predictors (business processes) at multiple levels within the organization. This information is provided in a continuous and regular basis for the purposes of facilitating timely "alternative choice decisions."

This proposal has been developed by David T. Menefee, Ph.D.

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Evaluating the Implementation and Impact of an Intervention Designed to Enhance Residential Treatment for Adolescents with Histories of Trauma

JEANNE C. RIVARD, PH.D.

Evaluating the Implementation and Impact of an Intervention Designed to Enhance Residential Treatment for Adolescents with Histories of Trauma is an evaluation study of the implementation of an intervention program (the Sanctuary Model, developed by Dr. Sandra Bloom) at several Jewish Board of Family and Children's Services' residential treatment facilities for adolescents. The program was originally developed for implementation in adult, short-term facilities. An evaluation of its suitability for a long-term adolescent facility as potentially important consequences for adding to the treatment options for adolescents with a history of trauma. This article describes the Sanctuary Model, the development of the intervention, and the challenges the intervention presents to the researcher.

Despite the strong associations between child maltreatment and psychological disorders in childhood and adulthood, there is evidence that child victims of abuse and neglect do not routinely receive mental health treatment specifically targeted to prevent or ameliorate potential negative mental health outcomes. Few empirical studies document outcomes of mental health interventions for abused and neglected children (Berliner, 1997; Cicchetti & Toth, 1995; Fantuzzo, 1990; Graziano & Mills, 1992; Malinowsky-Rummell & Hansen, 1993).

This article describes an initiative being undertaken by the Jewish Board of Family and Children's Services (JBFCS) to enhance residential treatment programming for emotionally disturbed children with histories of maltreatment and exposure to family and community violence. Under the auspices of JBFCS and through the consultation of Dr. Sandra Bloom (JBFCS Saul B. Cohen Chair of Mental Health for 1998-1999), the agency is piloting a model of trauma-based treatment for use in adolescent residential treatment centers. The intervention will be applied to existing therapeutic programs that are specialized in treating youth with conduct disorders and other serious emotional disturbances, but which have not traditionally utilized a trauma-based approach to directly treat the symptoms and consequences associated with child abuse, neglect, and exposure to family or community violence. The programs provide residential, therapeutic, and special educational services for children and adolescents referred by public child welfare, mental health, and juvenile justice agencies.

An evaluation component has been integrated into the planning and development of this multi-modal intervention. Several challenges are presented in both implementing and evaluating the model. First, the model was originally developed in a short-term, in-patient setting for adults suffering from traumatic experiences, so it must be adapted for adolescents in long-term residential settings. Second, in addition to adding a trauma-based focus to an existing residential treatment program, the model involves diffusing a new philosophical approach and changing the therapeutic milieu of programs.

The Sanctuary Model

The intervention, referred to as the Sanctuary Model (Bloom, 1997), is composed of three basic components: (1) philosophical tenets guiding the creation and maintenance of a therapeutic community; (2) a treatment approach, based in trauma theories and cognitive-behavioral treatment theories, that posits four stages of recovery for trauma survivors; and (3) a range of therapeutic modalities including psychoeducational modules designed to provide skills for restructuring thought processes, communication, and behavior to facilitate movement through the stages of recovery.

A primary goal of the intervention is to enhance the therapeutic milieu with a philosophy of non-violence and democratic social action in which staff and clients share responsibility for creating the therapeutic community. The philosophy is based on tenets of a therapeutic milieu developed in the 1940s to 1960s in an effort to humanize treatment within institutions and has been extended to other forms of community-based treatment (Bloom; Grob, 1991). The core values of a therapeutic community are: the community itself is the most influential factor on treatment; clients are responsible for their own treatment; the operation and management of the community should be more democratic than authoritarian; clients can facilitate each others' treatment; treatment is voluntary and conducted in the least restrictive environment; and physical restraint is kept to a minimum.

The Sanctuary Model adds to these values an emphasis on creating a "living-learning environment" which is physically, psychologically, socially, and morally safe for both clients and staff. In this milieu, conscious problem-solving is encouraged on personal, interpersonal, and community levels. Staff strive to create a non-hierarchical working atmosphere where decision-making is democratic and all members of the community are treated with high levels of respect and dignity. The professional roles and boundaries of staff are clearly distinguished from those of clients, without setting up physical or psychological barriers, and while empowering clients as influential community members and problem-solvers (Bloom).

This therapeutic community milieu sets the stage for delivering the trauma-based treatment aimed at facilitating client growth through four stages of recovery, represented by the acronym, SAGE (Foderaro & Ryan, 1998). *Safety* refers to creating a safe environment physically, psychologically, socially, and morally in which clients can engage in the recovery process within a non-threatening environment. Safety also refers to an individual's personal commitment to create internal safety by learning how to stop cycles of re-enacting traumatic experiences through hurting themselves (i.e., self-mutilation, addiction, setting up situations where they will be rejected by others, etc.). Attaining a feeling of safety is critical to the attainment of all other treatment goals. *Affect modulation* refers to the stage following safety in which individuals learn how to manage effectively their emotional responses. Important tasks for the clients in this stage are learning how to: accurately identify their various emotional states; discriminate between positive and negative affect in self and others; use cognitive and language skills to articulate their emotional states; read the emotional cues of others; and appropriately "recalibrate" the intensity of their emotional responses according to different levels of stimuli. *Grieving* is the stage of recovery in which individuals mourn losses they have experienced and practice managing the emotions that accompany such losses. Successfully reaching and getting beyond this stage of recovery allows individuals to re-focus—away from the past and toward the future. It calls for new effort to be spent in creating a new sense of self. *Emancipation* refers to the stage of recovery in which individuals are empowered to make choices to direct their lives toward more life-sustaining and growth-oriented goals. It is "characterized by an on-going process of self discovery and self definition, accompanied by an evolving sense of mastery" (Foderaro & Ryan).

The SAGE framework is operationalized through a range of cognitive-behavioral oriented therapeutic modalities including individual therapy, group therapy, and expressive therapies. Chief among these are group psychoeducational modules that are designed to teach the concepts inherent to the SAGE framework, and to teach and encourage the practice of the cognitive, language, and behavioral skills necessary to move through the stages of recovery within the safety of the therapeutic community.

Intervention Development and Research Challenges

Successful implementation of the Sanctuary Model in a treatment facility requires change at several levels—change in both the program philosophy and the milieu toward a non-violent and community-oriented paradigm, change in the organizational culture, change in the attitudes and behaviors of community members, and change in treatment protocols. Establishing and maintaining a therapeutic community in line with the Sanctuary Model requires an active process of breaking down institutional, societal, professional, cultural, and communication barriers that isolate clients and staff. Simultaneously, the re-building process involves consciously learning new ways to relate as interdependent community members, creating and modeling healthy and supportive relationships between individuals, and developing an atmosphere of hope and non-violence. In the JBFCS implementation of the Sanctuary Model, the primary means for effecting such change will be through increasing communication between staff and clients and including all members of the community in planning, shaping, and implementing the intervention within each specific treatment unit involved in the pilot project. In this manner, the new philosophy will be absorbed into the implementation process itself.

Measuring such change in the therapeutic milieu will require qualitative analyses of key events and interactions within the community, such as how plans and decisions are made, how critical incidents and problems are handled, and how youth are empowered to participate in planning, decision-making, and problem-resolution. Other areas of investigation related to implementation pertain to how individual, ethnic, and cultural differences among staff and clients affect the change process. For example, how are aspects of the new philosophy, such as non-violence, flattened hierarchy for decision-making, and open communication, interpreted and accepted by different members of the community? How do new feelings of interpersonal trust and safety emerge? How do staff involved in direct client care interpret trauma theories and integrate them into daily interactions with adolescents?

Evaluating outcomes of this type of multi-level intervention presents many challenges. The evaluation plan must consider questions such as: how can change in program philosophy and milieu be quantified and correlated with change in staff behavior/attitudes and client outcomes; how is the SAGE

treatment approach distinguished from existing treatment protocols; and how can the effects of the Sanctuary Model be separated from those resulting from the existing intervention? To evaluate the effects of the intervention both intermediate and ultimate outcomes need to be considered. Diffusion of the therapeutic community philosophy should lead to changes in the therapeutic community (i.e., intermediate outcomes), such as: greater sense of community/cohesiveness; more democratic decision-making and shared responsibility in problem-solving; reduction in use of physical restraints; and reduction of violent critical incidents. Diffusion of the therapeutic community philosophy and full implementation of the treatment approaches should result ultimately in gains for youth, such as: reducing trauma symptoms; increasing self-esteem; increasing self-control; and utilizing social networks.

For long range planning, a quasi-experimental, comparison group cohort design with repeated measures has been proposed to evaluate the effects of the intervention on the therapeutic milieu, staff, and youth. The evaluability of the logic model is, however, highly contingent upon the successful diffusion of the therapeutic community philosophy. This intervention development and research project has strong support within JBFCS. Due to the democratic and somewhat revolutionary nature of the new intervention, the programs are carefully soliciting input and participation from all levels of the organization, and they are cautiously advancing in embracing the new philosophy.

The study's principal investigator is Jeanne C. Rivard, Ph.D.

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Between Adolescence and Adulthood: How Young Adults with Mental Illness Perceive Their Treatment Needs

LISA V. BLITZ, M.S.

ANDRÉ M. IVANOFF, PH.D.

Between Adolescence and Adulthood: How Young Adults with Mental Illness Perceive Their Treatment Needs *is an exploratory study designed to investigate how seriously mentally ill young adults in a psychiatric rehabilitation and day treatment program perceive their treatment needs. Specialized programming will be developed to meet those needs based on the research results. The last phase will be an outcome study to determine the effectiveness of these specialized services. This article presents the study background, aims, and methods.*

Seriously mentally ill young adults between 18 and 25 years old are a vulnerable and little understood minority in the community mental health system. An increasing number of young adults with severe and persistent mental illness have been referred to day treatment programs from hospitals, outpatient clinics, and residential treatment facilities where they have "aged out", and from rehabilitation programs where they have "failed" treatment. These young adults often have difficulty adapting to the milieu culture of a treatment program which is designed for adults, but which does not provide specialized services to meet the needs of young adults. Their dissatisfaction with program services, their emotional reactions to the illness and disability of older clients, and their difficulty in feeling a sense of belonging are expressed verbally and behaviorally (e.g., acting out sexually or with drugs or alcohol). Their drop out and rehospitalization rates tend to be high.

These individuals hover between the last developmental stages of adolescence and the beginnings of full adulthood, even as they are treated by the mental health system as full adults. Since many of these clients never experienced institutionalization and have benefited from improved medication therapy, their needs frequently differ from those of older adults in day treatment programs. Moreover, to a 20-year-old client entering the adult mental health system for the first time, even a 35-year-old fellow patient seems old. The additional 15 years that this older adult has had struggling with his or her illness can be frightening and intimidating to the younger person.

Aims

This study is designed to investigate the problems and needs of mentally ill young people between 18 and 25 years old, a population that has received little attention from researchers and other writers in the field. A literature review revealed a wealth of articles about clinical treatment of disturbed adolescents in their teens as well as about mentally ill adults over the age of 18, but few articles regarding mentally ill young people between 18 and 25 years old.

Methods and Findings

The study is being conducted at the Bronx REAL [Rehabilitation and Education in the Art of Living], a Jewish Board of Family and Children's Services therapeutic community for seriously mentally ill adults, which uses group, individual, and vocational treatment in the context of milieu therapy. Since the program's inception in 1985 until approximately 1997, the client population had typically been between 30 and 50 years old. Beginning in early 1997, however, the program experienced a sudden influx of referrals of young adults in their late teens and early twenties, creating a significant shift in age distribution and mix.

It became apparent that as these young adults were admitted to the program, adjustments in treatment style and service delivery would be necessary in order to meet their needs. Program clinicians and case managers reported that the young adults were presenting unfamiliar issues. Program supervisors noted an increase in aggressive energy in the therapeutic community and were called upon more frequently to intervene in potentially violent incidents. To better serve this population, program administrators saw the need for modifications in service delivery and treatment style. Adolescent development theory, which typically interprets adolescence as a period of development that extends into the mid-twenties (Balk, 1995), suggested to staff that they were serving a population with different psychosocial and developmental needs from the program's typical population.

Accordingly, this study was designed to address these program needs. All young adult clients (between the ages of 18 and 25) who were enrolled in the JBFCS Bronx REAL between December 1, 1997 and March 31, 1998 were interviewed. A series of focus groups were held with the young adults to determine their perceptions of their issues and treatment needs; their attitudes toward the Bronx REAL program; and their impressions of how the program had been helpful to themselves and their peers. These focus groups led to the development of questionnaires used in subsequent interviews.

Records were kept of interactions between young adults and older adults; young adults and young adults; young adults and staff; and staff and staff regarding the young adult clients. Also, clients were asked a set of questions to determine their current problems and issues. A second set of focus groups was held to review the interview findings with the young adults.

The principal investigator and an administrative team at the JBFCS Bronx REAL conducted data analysis. This step consisted of analytic coding of the interview transcripts and field notes from the observations, focused coding to collapse and drop codes, and categorization to identify major themes, ideas and points.

The results of this analysis were used directly in the program development process, also conducted by this team. The findings were categorized into three groups: areas of need for service; treatment principles; and treatment and service priorities. The areas of need for service had three sub-themes: issues related to the developmental needs of young adulthood; interpersonal functioning in the program; and problems, coping skills, and service needs related to illness and disability. The treatment principles were grouped into six prescriptive standards: provide direct feedback to clients; maintain real, genuine relationships; emphasize skill building; approximate a school learning environment in the program structure; make program rules and expectations of clients clear and consistent; and ensure that consequences for rule violation are clear, objectively fair, and geared toward learning and growth.

The young adults' five highest treatment priorities were found to be: (1) help achieving a goal; (2) assistance with going to school or getting a job; (3) help setting a goal; (4) being around others of their same age; and (5) help resolving emotional problems. Their five lowest treatment priorities were found to be pertaining to: (1) questions regarding drugs or alcohol; (2) concerns about HIV/AIDS; (3) questions and issues about sex; (4) relationships with peers; and (5) issues with a boyfriend or girlfriend.

Use of Findings

Program development efforts continue to incorporate these findings in all areas of service provision. Specialized psychoeducational and psychotherapeutic groups have been established in response to these findings. Staff training and development have been redesigned to extend the incorporation of these treatment principles into clinical assessment and intervention. From the beginning of the data analysis phase of the project, the principal investigator has worked with a team of program staff to assess how the results impact program service delivery and treatment. The input of key staff members, who know the Bronx REAL system and program culture, was drawn upon to facilitate the integration of the new program into the existing milieu, and to ensure the backing and support of the treatment team of the program as specialized services began to be implemented. In spite of these cautions, however, implementation of the specialized services proceeded more slowly than anticipated.

Several incidents involving young adult clients participating in the program (e.g., thefts from staff, aggressive outbursts in the milieu, sexual contact in a locked group room, and substance abuse issues) have led some staff to question whether the program should expand its efforts to treat these young people. Effective implementation will require the cooperation of the entire treatment team. The principal investigator continues to work with the staff to provide education and to address staff fears and concerns.

The study's principal investigator is Lisa V. Blitz, M.S. The faculty consultant is André M. Ivanoff, Ph.D.

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The Social Context of Adolescent School Performance

MIMI V. CHAPMAN, PH.D.

The Social Context of Adolescent School Performance *is designed to examine the intersection of neighborhood influences, family environment, traumatic life events, and adolescent depressive symptoms and school performance. Data is being collected at the Youth Counseling League (YCL), a program of the Jewish Board of Family and Children's Services. This article presents the study's rationale and methodology.*

School performance has long been seen as a predictor for future life chances. The consequences of school difficulties have become greater as advanced training increasingly becomes necessary to sustain a basic level of living (Hurrelman, Engel, Holler, & Nordlohne, 1988). School failure, however, does not occur in a vacuum. It is a complex problem with a variety of possible antecedents and often masks mental health problems. With its complex causes and consequences, poor school performance is an area in which social workers are often asked to intervene. The study described in this article uses an ecologically based empirical model to address the multiple dimensions of adolescent school performance.

Ecological theory posits that developing adolescents both mold and are molded by their environment. Although adolescents make free choices about behavior, this theory stresses the important roles societal structures and significant interpersonal relationships play in shaping those choices (Garbarino, 1992). Adolescents growing up in the shadow of a new century must negotiate a variety of changes in the social context. As family structures change, many adolescents must look beyond their parents and siblings for support. School experiences may provide an environment for developing adolescents to interact with a variety of adults, form bonds with peers, and experience mastery over topics that will prepare them for adult life.

Many educational institutions are under severe strain, making it difficult for adults in the school environment to reach out to teens needing support (Jackson, Felner, Millstein, Pittman, & Selden, 1993). Certainly, peers create an important context in which teens seek to solidify a permanent identity, but the ability of peers to provide the type of support needed to succeed in school is questionable (Richman, Rosenfeld, & Bowen, 1998). Television reportedly fills at least 3 hours of each school day for over 50% of adolescents in the United States, a finding that raises concerns about the level of involvement between teens and other caring individuals, be they peers or adults (Louis Harris & Associates, 1997).

As adolescents confront the task of identity formation, they often experiment with new roles and behaviors in life domains outside of family and school. This widening sphere of interactions makes neighborhood another potentially powerful influence on adolescent outcomes. Unfortunately, many neighborhoods no longer provide the support and informal monitoring that once afforded youth with role models and supported parents in imparting prosocial values to their adolescent children. Violence, decreased social connections, and other changes have eroded once strong neighborhoods (Wilson, 1995). Although families have traditionally been seen as mediators between their offspring and the larger world, the task of monitoring and shielding adolescents from what some call a "socially toxic environment" has become increasingly difficult (Garbarino, 1994).

On balance, the literature suggests that adolescents may be experiencing an impoverished support network in many life domains. This changing context makes negotiating adolescence a risky endeavor in the best of circumstances. Consider then the difficulties faced by youth coming to this developmental phase with a history of traumatic life events occurring prior to or during their teenage years. Trauma has been linked to school failure, depressive symptoms, and disruptive behavior, but the influence of past trauma is often obscured by the presenting symptoms (Carlson, 1997; Gil, 1996). Research to date suggests that failing to attend to traumatic experiences may result in symptoms associated with decreased academic and social functioning, greater levels of mental health difficulties, and increased drug and alcohol abuse (Garbarino, Dubrow, Kostelny, & Pardo, 1991; Herman, Perry, & van der Kolk, 1989; Wilson & Raphael, 1993). Significantly, each of these outcomes has also been linked to neighborhood context and family environment variables (Brook, Nomura, & Cohen, 1989; Durant, Getts, Cadenhead, Emans, & Woods, 1995; Gonzales, Cauce, Friedman, & Mason, 1996). Neighborhood context and family environment have also been linked in the literature (Coulton, Korbin, Su, & Chow, 1995; Klebanov, Brooks-Gunn, & Duncan, 1994; Simons, Johnson, Conger, & Lorenz, 1997). Taken together, these findings suggest a pattern of inter-relationships among neighborhood context, family environment, and traumatic experiences in producing outcomes such as depressive symptoms and school failure.

This study uses a cross-sectional design to test an empirical model of hypothesized associations among neighborhood influences, family environment, traumatic life events, and adolescent depressive symptoms and school performance.

Study participants come from the Youth Counseling League (YCL), a program of the Jewish Board of Family and Children's Services. A consecutive referrals sample is being used. All clients coming to YCL during the data collection period are being invited to participate in the research project as part of the routine assessment process. Completion of an on-line survey, The School Success Profile (Bowen & Richman, 1995), and a traumatic life events checklist are being used to gather data on the study variables. In order to attain the largest possible sample, data collection will extend over a full year. Following multiple training and protocol revisions and discussions with YCL staff, data collection for this project began on December 6, 1999.

The study's principal investigator is Mimi V. Chapman, Ph.D.

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A Proposed Study: Client Improvement and Disposition upon Termination from Outpatient Mental Health Clinics: Impacts of Cultural Factors and Health Insurance upon Psychotherapy and Medication Treatment

RICHARD B. FRANCOEUR, PH.D.

Client Improvement and Disposition upon Termination from Outpatient Mental Health Clinics: Impacts of Cultural Factors and Health Insurance upon Psychotherapy and Medication Treatment *is a proposed study. It will assess whether cultural factors influence how clients' type of health insurance predisposes them not to improve during medication treatment, a phenomenon that may be linked to unaffordable out-of-pocket drug costs or a desire for greater access to psychotherapy.*

During 1993-1998, antidepressants were ranked within the top four categories of all prescribed drugs in terms of cost increases (McGinley, 1999). At the outpatient mental health clinics operated by the Jewish Board of Family and Children's Services (JBFCS), reimbursement rates across all payers for twenty-minute medication visits are much higher than for one-hour psychotherapy visits. This difference suggests that there may be incentives for medication treatment regardless of whether clients are insured for psychiatric medications or can afford the out-of-pocket costs. The disparate reimbursement rates also might influence the substitution of medication treatment for psychotherapy, when psychotherapy may be more efficacious, cost-effective, and/or preferred by clients.

These two concerns are particularly significant in light of the continuing rise of expenses at these outpatient mental health clinics, despite the peaking of managed care and Medicaid reimbursement rates. In recent years, the mental health reimbursement system has begun moving towards a system of annual capitation (e.g., $5,000 per client). This system of limited total reimbursement provides strong incentives for agencies to adopt cost-effective clinical practices and medication management. In this changing fiscal environment, clients who do not comply with medication treatment demands, because of unaffordable out-of-pocket prescription costs or a desire for greater access to psychotherapy, may generate excessive financial costs for the agency. In addition to issues of financial burden, cultural factors such as ethnicity and socioeconomic status may impede client improvement or compliance with care.

For some cultural subgroups of clients, with particular types of health insurance and DSM-IV diagnoses, an increase in the number and/or proportion of psychotherapy visits might lead to cost-effective improvement in client condition and disposition at treatment termination. Alternatively, these effects may either generalize across cultural subgroups or occur within specific subgroups regardless of the number and/or proportion of psychotherapy visits. Cultural factors might exacerbate the effects of financial burden to clients. Within some Hispanic communities, for example, access to indigenous remedies and faith-based healing and/or the disproportionate lack of insurance (Kilborn, 1999) might result in resistance to co-payments and out-of-pocket costs even when insured clients can afford them.

The Proposed Study

The proposed study will be an analysis of program monitoring data from fiscal year 1997-98 for three JBFCS outpatient mental health clinics. The analyses will focus upon specific DSM-IV diagnoses

for singular and comorbid depression and anxiety. Findings should yield insights for treatment monitoring and program planning for particular client subgroups, based upon cultural factors (gender, ethnicity, age, household composition, and income source); type of health insurance; and psychotherapy and medication treatment (frequency of each type of visit, duration of overall treatment episode).

Human service agencies frequently contend with incomplete and imperfect program monitoring data. The data used in the proposed study might not capture all of the important predictive factors. To tease out predictive factors, a unique and promising statistical approach will be used. This approach adjusts for unmeasured factors during the simultaneous estimation of a set of contingent, highly associated predictive equations based upon the same measured factors. The first equation predicts client condition at treatment termination (i.e., deteriorated, unchanged or indeterminate, improved), while the second equation predicts client disposition at termination (i.e., withdrew, completed care, referred to other continuing care). The proposed study will be a demonstration of this innovative, practical approach for program monitoring/evaluation within a major human services agency.

Exploratory analyses will be conducted and explanatory hypotheses will be tested when warranted. For cultural subgroups of clients receiving only medication treatment, it is hypothesized that HMO clients who do not incur out-of-pocket prescription costs are more likely than other clients to complete contracted care in improved condition. For cultural subgroups of clients receiving both medication and psychotherapy treatment, it is hypothesized that more frequent psychotherapy visits and lower proportions of medication-to-psychotherapy visits predict positive outcomes (i.e., clients completing care in improved condition), beyond what may be predicted from the number of visits for medication management. In comparison to the effects for HMO clients, significantly higher effects for non-HMO clients, who incur out-of-pocket prescription costs, would signal that increases in psychotherapy visits and decreases in the proportions of medication-to-psychotherapy visits appear more effective for them. For these non-HMO clients, psychotherapy may substitute for medication visits associated with unaffordable prescriptions and/or may counteract the reduced effectiveness of medication visits already incurred.

To complement the focus upon predictions of positive and negative outcomes, the study will also consider the extent to which type of health insurance predicts the frequencies of psychotherapy and medication visits, as well as the duration of the treatment episode. It is hypothesized that HMO and Medicaid clients — who do not incur out-of-pocket prescription costs — tend to incur more medication visits, fewer psychotherapy visits, a higher proportion of medication-to-psychotherapy visits, and shorter psychotherapy treatment episodes than do other clients. The proposed study will determine if these hypotheses, tested for women in the National Ambulatory Medical Survey (1990-94) (Glied, 1997), are robust among cultural subgroups of women, as well as men, within the three JBFCS outpatient mental health clinics. The treatment decisions at these and many other clinics are influenced by the same unstable economic and organizational factors.

The principal investigator of this proposed study is Richard B. Francoeur, Ph.D.

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